Department of Community and Human Services

Report on Equity and Social Justice Commitment Outcomes

January 2011

This page is intentionally left blank.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The King County Department of Community and Human Services (DCHS) has a long history of ensuring its services meet the needs of our diverse community. Since the inception of King County's Equity and Social Justice Initiative (ESJI) in 2008 and its formalization as a county policy through Ordinance 16948 in September 2010, DCHS has annually analyzed data to determine whether any racial/ethnic disparities are present for its services. As required by the County Executive, the findings of these analyses have been presented in annual reports. To date, DCHS has produced two ESJI commitments reports, in April and December 2009. In addition, it has regularly updated the results of these evaluations through other reporting frameworks.

For 2010, DCHS committed to replicate some of its past ESJI analyses of racial/ethnic differences in client access to and outcomes for its programs. In addition, it agreed to study several social justice issues specific to a few of its individual program areas. The findings for DCHS' 2010 ESJI commitments are presented below.

Mental Health, Chemical Abuse, and Dependency Services Division (MHCADSD)

Service Access- For outpatient mental health treatment, outpatient substance abuse treatment, and opiate substitution treatment enrollment rates, findings were consistent with previous years. Most U.S. Census-defined racial groups (e.g. American Indian/Alaskan Native, Asian/Pacific Islander, African American/Black, White, Two or More Races) and the Hispanic/Latino ethnicity were only slightly over or underrepresented among service users, save American Indians/Alaskan Natives and Asians/Pacific Islanders.

- American Indians/Alaskan Natives had nearly a 180 percent increase in their representation among these service populations as compared to the previous years studied. Across all services mentioned, they were seen at two to five times their proportion of the service eligible population.
- Asians/Pacific Islanders continued to be underrepresented by nearly twofold across all service areas studied.

Outpatient Chemical Dependency Treatment Outcomes for Ethnic Specialty Providers versus Non-Specialty Providers- In King County, several outpatient chemical dependency treatment providers are considered to be specialized in serving particular racial/ethnic groups. It is presumed by many that such providers have better outcomes for their target populations than when such groups are served by non-specialty agencies. MHCADSD staff tested this hypothesis by comparing whether Asians/Pacific Islanders, Hispanics/Latinos, American Indians/Alaskan Natives, and Blacks had better treatment completion and retention (e.g. remaining in treatment for 90 or more days) outcomes if they received services from an ethnic specialty provider for their ethnic group versus a non-specialty provider.

Overall, the outpatient chemical dependency treatment results for both completion and retention for Asians/Pacific Islanders and Hispanics/Latinos were significantly better at the ethnic specialty provider agencies than at the non-specialty agencies. Also, treatment retention was better for American Indians/Alaskan Natives at one ethnic specialty provider. Based on service population size or percentage, there is no true specialty provider for the Black population. Also, no agency showed significantly better outcomes for this population than the system as a whole.

Metabolic Syndrome in Mental Health Clients on Atypical Antipsychotics- Individuals with mental illness tend to die, on average, about 25 years younger than the general population. One of the factors contributing to their lower life expectancy is a metabolic syndrome characterized by high lipid levels, obesity, hypertension, and diabetes. Individuals taking second generation antipsychotic medications known as "atypicals" are at particular risk for this syndrome.

MHCADSD conducted a prevalence assessment to determine if there are any racial/ethnic differences in the prevalence rate of metabolic syndrome among those on atypical antipsychotic medication. This research found that the true disparity for metabolic syndrome is not between racial/ethnic groups who suffer from mental illness. Rather, it is the overall rate of metabolic syndrome in this population compared to the general population, with obesity and other metabolic syndrome indicators occurring at roughly triple their typical prevalence rate.

Developmental Disabilities Division (DDD)

Service Access- Similar to its previous years' findings, nearly all Census racial groups and the Hispanic/Latino ethnicity were proportionately represented among children enrolled in Birth-to-Three early intervention services to address their developmental delays.

Service Outcomes- Due to the small numbers of children from all Census racial groups except Whites utilizing early intervention services, outcome findings were unreliable. Nonetheless, from 2005 to 2009, the number of children exiting services who did not require special education by their third birthday steadily increased for Asians/Pacific Islanders, Whites, and Hispanics/Latinos. For American Indians/Alaskan Natives and Blacks, the number of children in this same category stayed constant or dropped slightly.

Evaluation of Early Intervention Pilot Project – Beginning in 2008, DDD partnered with the early learning agency SOAR to conduct early intervention outreach to the Somali, Vietnamese, and Hispanic/Latino communities. Trusted members of these communities were hired as community liaisons to provide this service. In 2009, 562 families from these communities were reached, well above the goal of 300.

- Two hundred and sixty four Hispanic/Latino families were contacted, 50 of whom requested follow-up for early intervention enrollment.
- Two hundred Vietnamese families were reached. Of these, 30 asked for assistance in accessing early intervention services.
- Ninety-eight Somali families were contacted. Sixteen of these asked for follow-up on early intervention enrollment.

Of the 96 families that requested follow-up for early intervention services, 38 have been referred to services with the Department of Social and Health Services/Division of Developmental Disabilities (DSHS/DDD). Due to confidentiality issues, DDD is unable to learn how many of these were enrolled in services.

Based upon surveys SOAR conducted, families were satisfied with their contact and service experience. Nonetheless, it appears that parents are still reluctant to call DDD and that the families need guidance during the process of getting services. Also, some families found the referral process too long and confusing in languages other than English. In addition, most affected families prefer private face-to-face meetings as their introduction to learning about the developmental disabilities service system.

Community Services Division (CSD)

Service Access - Asians/Pacific Islanders, Whites, and American Indians/Alaskan Natives had results consistent with those of previous years; Asians/Pacific Islanders were quite underrepresented amongst CSD-contracted homeless service (e.g. basic needs (food, clothing vouchers, rental assistance), homeless prevention assistance, emergency shelter, transitional housing, and permanent supported housing) clients, Whites were slightly underrepresented, and American Indians/Alaskan Natives were well overrepresented.

Hispanics/Latinos decreased in their percentage of CSD-contracted homeless service clients. They remain slightly overrepresented overall.

Blacks increased in their overrepresentation among CSD-contracted homeless service clients. One explanation for this change may be the corresponding drop in the percentage of persons identifying as "Two or More Races" over the same period studied.

Service Outcomes - There appears to be no statistically verifiable difference in the rates by which different Census racial groups and the Hispanic/Latino ethnicity move from emergency shelters to transitional or permanent housing. Likewise, no statistically significant difference was found in the percentages of different Census racial groups and the Hispanic/Latino ethnicity that moved from transitional to permanent housing.

Examining the Underrepresentation of Asians/Pacific Islanders Among CSD-Funded Homeless Service Clients- CSD researchers found that Asians/Pacific Islanders are underrepresented among CSD-funded homeless service clients due to two primary reasons: 1) Asians/Pacific Islanders are more likely to rely on family/friends during housing and/or economic crises; and 2) Barriers to the homeless services system are intensified by language and cultural issues. To address these barriers, they recommend:

- Improving service access for immigrants and refugees. Asians/Pacific Islanders experience many of the same service barriers as other groups with high immigrant and refugee populations;
- Developing interventions for the housing issues experienced by Asians/Pacific Islanders and other groups less likely to seek homeless services, such as assistance to households living in overcrowded units on landlord/tenant relationships;
- Supporting the cultural competence of housing and support service providers; and
- Ensuring that the coming improvements to the system benefit all groups, including Asians/Pacific Islanders. These include the implementation of a coordinated entry system for families accessing homeless services and the shift from focusing on emergency shelter and transitional housing to preventing homelessness.

INTRODUCTION

The King County Department of Community and Human Services (DCHS) has a long history of ensuring its services meet the needs of our diverse community. Since the inception of King County's Equity and Social Justice Initiative (ESJI) in 2008 and its formalization as a county policy through Ordinance 16948 in September 2010, DCHS has annually analyzed data to determine whether any racial/ethnic disparities are present for its services. As required by the County Executive, the findings of these analyses have been presented in annual reports. To date, DCHS has produced two ESJI commitments reports, in April and December 2009. In addition, it has regularly updated the results of these evaluations through other reporting frameworks.

DCHS has focused its research on those of its programs that have the greatest potential for leading service system changes. These services are administered by DCHS and provided through contracts with community-based providers. For the past two years, these have consisted of the following three target programs:

Birth-to-Three Early Intervention Services – Managed by the Developmental Disabilities Division (DDD), these consist of assessment and support services to any child under the age of 36 months who resides with a Washington resident and has a 25 percent delay or is at or below the seventh percentile for his or her age in one or more of the following developmental areas: cognitive development, physical development (including vision, hearing, and fine and gross motor skills), communication development, social or emotional development, and adaptive development.

Homeless Services – Consist of services to prevent homelessness as well as housing for those experiencing homelessness. Homeless prevention services include basic needs assistance (food, clothing vouchers, and financial awards) and other supports such as foreclosure counseling and third-party agreements with landlords.

The housing provided to persons experiencing homelessness can be broken into three housing types: emergency shelter[1], transitional housing[2], and permanent supportive housing[3]. Each of these housing categories has separate programs for individual males and individual females. Families with children are also provided with separate housing in emergency shelters and transitional housing programs. DCHS' Community Services Division (CSD) manages contracts for these programs.

Mental Health and Substance Abuse Services – Administered by DCHS' Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD), these are made up of two separate programs- Outpatient Mental Health Treatment and Outpatient Substance Abuse Services.

Outpatient Mental Health Treatment – Community mental health treatment for persons whose needs can be met in an outpatient setting. Services include crisis interventions, case management, psychotherapy, psychiatric and medical attention, medication management, and job training. These supports are provided by licensed community mental health centers. MHCADSD administers this program, largely through the use of independent not-for-profit contractors.

[1] Refers to those housing programs that provide one-night stays to clients, often on a drop-in basis.

[2] Those housing units provided for up to 24 months and sometimes longer, to assist a formerly homeless household in making the transition to permanent housing. Transitional housing includes case management and other services, depending on the needs of the population being served.

[3] These are programs that provide permanent housing linked with support services for households who formerly experienced homelessness and who have serious mental illness, drug/alcohol addiction and/or HIV/AIDS. The purpose of the support services is to help households succeed in permanent housing and maintain their health.

Outpatient Substance Abuse Services **-** Also managed by MHCADSD, these involve two distinct types of treatment: outpatient substance abuse treatment and opiate substitution treatment. Outpatient substance abuse treatment consists of services to help people with substance abuse problems learn about and understand their addiction and ways to live without using alcohol and/or drugs. These programs primarily use individual and group counseling. Opiate substitution treatment is the use of methadone[4] or buprenorphine[5], typically combined with behavioral therapies[6], to treat addictions to heroin, prescription narcotic painkillers, and other opiates.

This report presents the findings from DCHS' 2010 ESJI research commitments. It builds upon the results of DCHS' April 2009 and December 2009 ESJI reports (*see Appendix A for summaries*).

ORGANIZATION OF REPORT

This report is organized into four parts:

I. Mental Health, Chemical Abuse, and Dependency Services Division (MHCADSD) Commitments and Findings

II. Developmental Disabilities Division (DDD) Commitments and Findings

III. Community Services Division (CSD) Commitments and Findings

IV. Conclusion and Recommendations

Parts I through III present and discuss the findings associated with the corresponding division's 2010 ESJI commitments.

Part IV draws conclusions from the analysis and provides recommendations for DCHS' 2011 ESJI commitments.

DEFINITIONS

Parity – This refers to the comparison of a population's representation within a subgroup as compared to the overall population. For instance, if Blacks comprise 10% of clients receiving Birth-to-Three early intervention services and represent 10% of the service eligible population, they are considered to be at parity. To determine service eligibility for all target programs except Birth-to-Three early intervention services, the percentage of individuals from each racial/ethnic group living at or below the Federal Poverty Level (FPL) was used as a proxy. This is because all of the target programs save the Birth-to-Three early Intervention services serve very poor clients, many of whom have incomes at or below the FPL. As a federal mandate, Birth-to-Three early intervention services are available to all residents, regardless of income.

Racial/ethnic groups - These are the Census racial categories of American Indian/Alaskan Native, Asian/Pacific Islander, African American/Black, White, Two or More Races and the ethnicity of Hispanic/Latino. For the purposes of this report, the term Black is used instead of African American. This is because many African immigrants are included in the data studied and the term Black is more inclusive of this population.

[4] A synthetic opiate that blocks the effects of opiates and stops withdrawal symptoms. It is proven to be very successful for people addicted to opiates.
[5] A newer medication which has a lower risk of addiction than methadone.
[6] In treatment, patients learn to replace drug-using activities, improve problem-solving skills, and learn relapse prevention strategies. Behavioral treatment may be even more effective when used with medication-assisted treatments.

MENTAL HEALTH, CHEMICAL ABUSE AND DEPENDENCY SERVICES DIVISION (MHCADSD) 2010 ESJI COMMITMENTS AND FINDINGS

MHCADSD agreed to the following ESJI commitments in 2010:

Commitment 1- Update Parity Analyses on Outpatient Mental Health and Substance Abuse Treatment Enrollment Rates – Replicate previous years' analyses of access rates to mental health and substance abuse services across racial/ethnic groups.

Commitment 2 - Compare Outpatient Chemical Dependency Treatment Outcomes for Ethnic Specialty Providers versus Non-Specialty Providers – Compare the outcomes of outpatient chemical dependency treatment providers who are identified by community perception as specialty providers for the Black, American Indian/Alaskan Native, Asian/Pacific Islander, and Hispanic/Latino populations respective to those of all other providers in the system.

Commitment 3 – Conduct an Ethnicity-Based Prevalence Assessment of Metabolic Syndrome[7] in Mental Health Clients on Atypical Antipsychotics[8] - Complete an ethnicity-based prevalence assessment to determine if there are racial/ethnic differences in the prevalence of metabolic syndrome among those on atypical antipsychotic medications. If there are racial/ethnic differences, work with providers on identifying contributing factors to disparity (e.g. access to care/genetic predisposition). If contributing factors are modifiable, develop a plan with providers for addressing the contributing factors and reducing disparity.

Commitment 4- Division-wide Commitment - Work closely with other divisions to ensure evaluation efforts are as coordinated and efficient as possible.

Commitment 1: Update Parity Analyses on Outpatient Mental Health and Substance Abuse Service Enrollment Rates

For outpatient mental health treatment, outpatient substance abuse treatment, and opiate substance abuse treatment enrollment rates, results from parity analysis were essentially equivalent those from previous years, with little exception. For most groups, parity was just slightly over or under 1.0[9] for all services.

- Asians/Pacific Islanders held to their representation at about half of parity for outpatient mental health treatment. Likewise, they continued to access substance abuse treatment at about one-third of their representation in the service eligible population.

- Blacks continued to utilize both mental health and substance abuse treatment services at rates similar to previous years. Overall, Blacks are accessing these services at above parity, with the exception of Black children/youth. The latter group was underrepresented among outpatient chemical dependency

[7] This is a syndrome characterized by high lipid (e.g. fat) levels, obesity (as demonstrated by high body mass index (BMI) ratios), hypertension, and diabetes.

[8] These are second-generation medications commonly used to treat schizophrenia, and sometimes bipolar disorder, that cause fewer motor side effects (such as tremors, gait disturbance, etc.) than the first generation of psychoactive medications on the market. They are often the first line of treatment for significant mental illness.

[9] A parity figure of 1.0 indicates that the group is served equally to its proportion in the reference population (e.g. for mental illness and substance abuse services as well as CSD-funded homeless services this is percentage of persons in same racial/ethnic group with incomes at or below the Federal Poverty Level). Figures above or below 1.0 signify a population is over or underrepresented respectively in the client population.

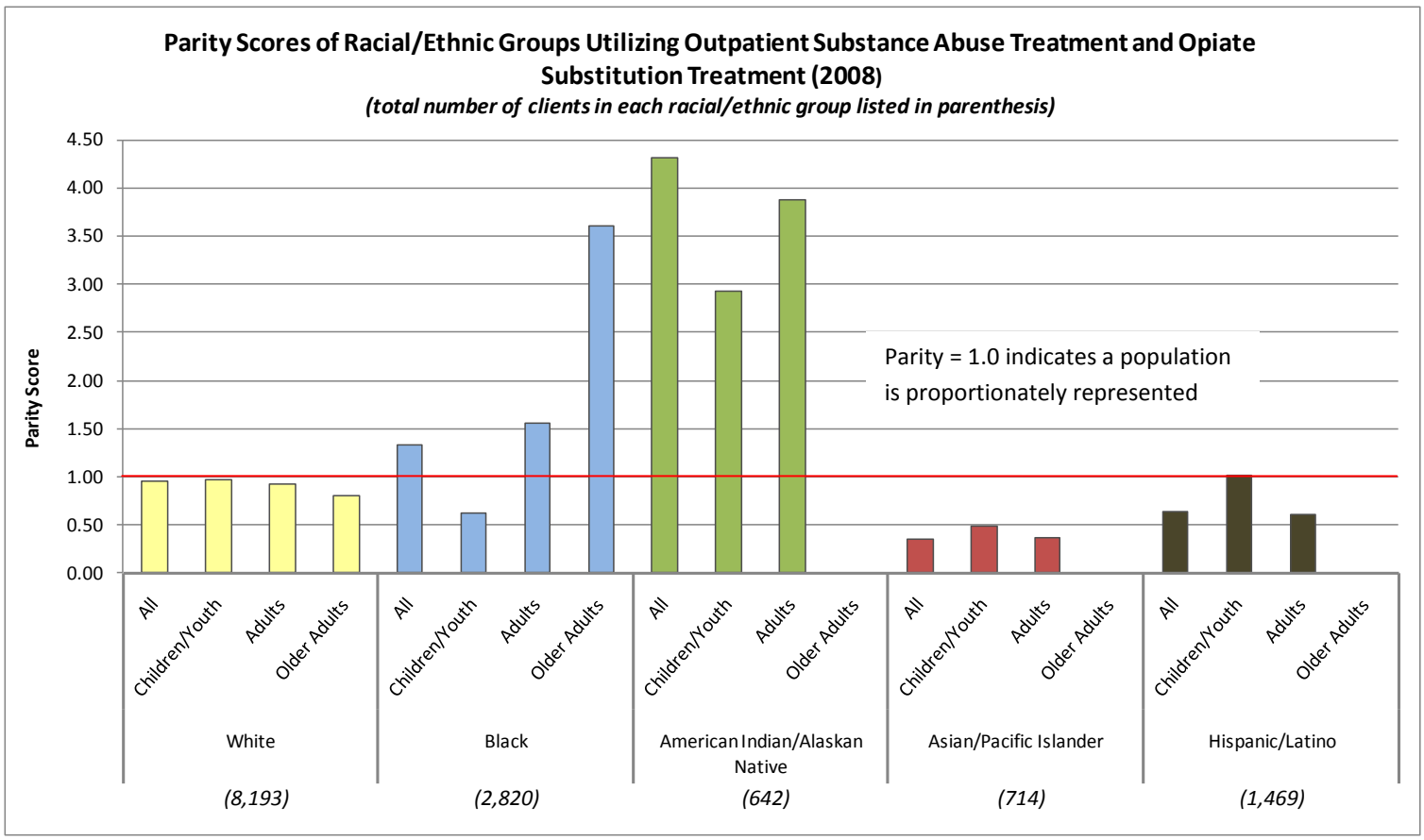
treatment[10] and outpatient mental health treatment clients. According to nationwide prevalence data, Black youth are less likely to use alcohol and illicit drugs as compared to Whites.[11]

- Parity scores for Hispanics/Latinos dropped slightly from 2008 to 2009, although they are being served in similar percentages as in previous years. Older Hispanic/Latino adults (e.g. over age 65) and children/youth (e.g. under age 24) continued to access services closer to parity than Hispanic/Latino adults.

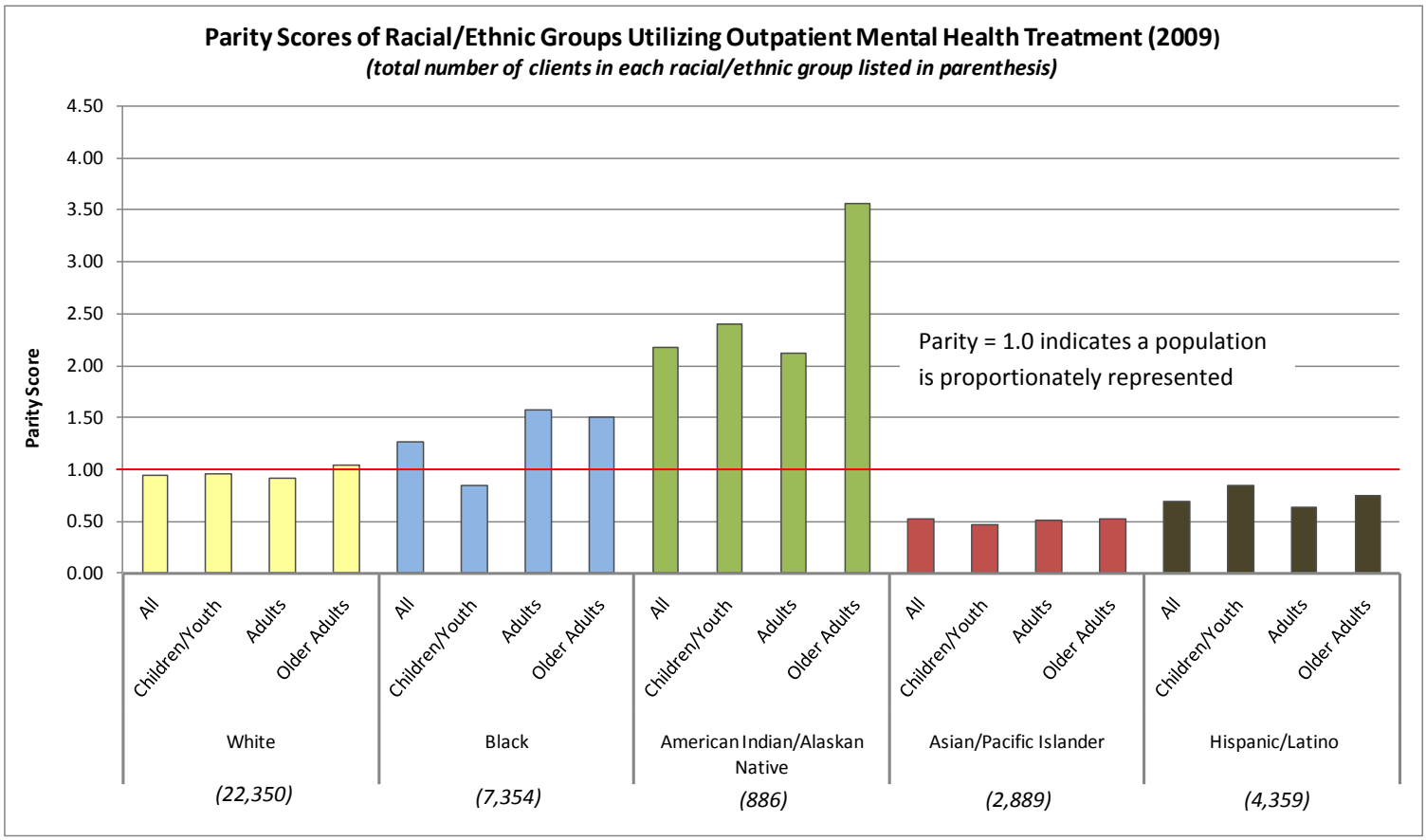
- American Indians/Alaskan Natives had nearly a 180 percent increase in their overall parity scores in comparison to the previous years studied. They are being seen at two to five times their population rate in the eligible population. Although their parity scores increased, they remained the same percent of the overall population served: two percent of those receiving mental health services, five percent of those receiving chemical dependency outpatient treatment, and three percent of those receiving opiate substitution treatment.

  American Indians/Alaskan Natives comprise only one percent of the eligible population. It should be noted that their numbers are very small, so small changes in numbers may result in large percentage changes.

[10] Children/youth under 18 are not legally allowed to access opiate substitution treatment.
[11] Office of Applied Studies - Substance Abuse and Mental Health Services Administration (SAMSHA) (2008). *Prevalence of Substance Use Among Racial & Ethnic Subgroups in the U.S.* http://oas.samhsa.gov/NHSDA/Ethnic/ethn1007.htm#E10E5



Note: Children/Youth received only Outpatient Substance Abuse Treatment, as any person under 18 is ineligible for Opiate Substitution Treatment. No values are shown for American Indian/Alaskan Native, Asian/Pacific Islander and Hispanic/Latino Older Adults due to less than 30 individuals belonging to each of these categories.



Reported Race or Ethnicity	2008 King County Population Estimate				People Served, 2009								Parity (% of pop or service group compared to "% <FPL")					
	Number		% of Total		Mental Health Services		Substance Abuse Services						King County		MH	SA Service		
							Any		Outpatient		Opiate Sub Tx							
	All	<FPL	All	<FPL	#	%	#	%	#	%	#	%	All	<FPL	Serv	Any	OP	OST
All Ages																		
White Alone	1,342,727	100,242	73	60	22,350	57	8,193	57	5,381	52	2,178	75	1.22	**1.00**	0.95	0.96	0.87	1.26
Black Alone	104,338	24,827	6	15	7,354	19	2,820	20	2,309	22	339	12	0.38	**1.00**	1.27	1.33	1.50	0.79
AI/AN Alone	12,519	1,746	1	1	886	2	642	4	491	5	97	3	0.65	**1.00**	2.17	4.31	4.53	3.22
API Alone	252,593	23,678	14	14	2,889	7	714	5	637	6	52	2	0.97	**1.00**	0.52	0.35	0.43	0.13
Other Alone**	56,939	9,769	3	6	*3,333*	*8*	*1,375*	*10*	*1,116*	*11*	*150*	*5*	0.53	**1.00**	*1.46*	*1.65*	*1.84*	*0.89*
Two or more	77,498	8,027	4	5	2,564	7	605	4	508	5	85	3	0.88	**1.00**	1.37	0.88	1.02	0.61
Total	**1,846,614**	**168,289**	**100**	**100**	**39,376**	**100**	**14,349**	**100**	**10,442**	**100**	**2,901**	**100**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**
Hispanic/Latino	142,272	26,969	8	16	4,359	11	1,469	10	824	8	174	6	0.48	**1.00**	0.69	0.64	0.49	0.37
Children/Youth*	(<18)				(<18)		(<18)											
White Alone	260,275	18,497	65	45	3,930	44	676	44	676	44			1.43	**1.00**	0.96	0.97	0.97	
Black Alone	27,810	9,545	7	23	1,791	20	225	15	225	15			0.30	**1.00**	0.85	0.63	0.63	
AI /AN Alone	2,653	371	1	1	196	2	41	3	41	3			0.73	**1.00**	2.40	2.94	2.94	
API Alone	53,583	5,314	13	13	542	6	98	6	98	6			1.03	**1.00**	0.46	0.49	0.49	
Other Alone**	18,734	3,825	5	9	*1,236*	*14*	*361*	*24*	*361*	*24*			0.50	**1.00**	*1.47*	*2.51*	*2.51*	
Two or more	36,793	3,181	9	8	1,289	14	132	9	132	9			1.18	**1.00**	1.84	1.10	1.10	
Total	**399,848**	**40,733**	**100**	**100**	**8,984**	**100**	**1,533**	**100**	**1,533**	**100**			**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	
Hispanic/Latino	50,402	10,350	13	25	1,908	21	394	26		0			0.50	**1.00**	0.84	1.01	0.00	
Adults	(18-64)				(18-59)		(18-59)		(18+)									
White Alone	919,750	70,353	74	64	14,575	59	7,372	59	4,705	53	2,178	75	1.15	**1.00**	0.92	0.92	0.82	1.17
Black Alone	68,976	14,205	6	13	5,037	20	2,533	20	2,084	23	339	12	0.43	**1.00**	1.58	1.56	1.95	0.98
AI /AN Alone	9,050	1,323	1	1	630	3	585	5	450	5	97	3	0.60	**1.00**	2.12	3.88	4.69	3.10
API Alone	175,486	13,816	14	13	1,579	6	587	5	539	6	52	2	1.12	**1.00**	0.51	0.37	0.42	0.12
Other Alone**	36,513	5,514	3	5	*1,658*	*7*	*994*	*8*	*755*	*8*	*150*	*5*	0.58	**1.00**	*1.34*	*1.58*	*1.82*	*1.11*
Two or more	39,060	4,782	3	4	1,216	5	465	4	376	4	85	3	0.72	**1.00**	1.13	0.85	1.11	0.77
Total	**1,248,835**	**109,993**	**100**	**100**	**24,695**	**100**	**12,536**	**100**	**8,909**	**100**	**2,901**	**100**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**
Hispanic/Latino	87,205	15,441	7	14	2,170	9	1,059	8	824	9	174	6	0.50	**1.00**	0.63	0.60	0.71	0.46
Older Adults***	(>64)				(>59)		(>59)											
White Alone	162,702	11,392	82	65	3,845	67	145	52					1.27	**1.00**	1.04	0.80		
Black Alone	7,552	1,077	4	6.1	526	9.2	62	22					0.62	**1.00**	1.51	3.61		
AI /AN Alone	816	52	0	0	60	1	16	6					1.39	**1.00**	3.56	19.30		
API Alone	23,524	4,548	12	26	768	13	29	10					0.46	**1.00**	0.52	0.40		
Other Alone**	1,692	430	1	2	*439*	*8*	*20*	*7*					0.35	**1.00**	*3.15*	*2.92*		
Two or more	1,645	64	1	0	59	1	8	3					2.28	**1.00**	2.84	7.84		
Total	**197,931**	**17,563**	**100**	**100**	**5,697**	**100**	**280**	**100**					**1.00**	**1.00**	**1.00**	**1.00**		
Hispanic/Latino	4,665	1,178	2	7	281	5	16	6					0.35	**1.00**	0.74	0.85		

*Children under 18 are not eligible for Opiate Substitution Treatment; therefore all opiate substitution cells in the children/youth rows are blank.

** Percentages for "Other (race) Alone" of "People Served" are italicized because they include unknown, making comparison to the population percentage not meaningful.

*** Because some racial/ethnic groups have very small numbers of older adults who received Outpatient and Opiate Substitution Treatment substance abuse services, the older adult substance abuse numbers cannot be broken out by treatment modality. The numbers for older adults were combined with those for adults under 60, and parity is calculated from the percentages for that combined age group. Those combined percentages are not shown on the report.

Discussion

Given that parity scores for all racial/ethnic groups, and nearly all age ranges for these groups, remained constant, no further investigation of this issue is deemed necessary. Based on national trends and the research conducted on Asians/Pacific islanders discussed in last year's report, MHCADSD believes that a parity target of 0.5 would be reasonable for serving this population.

Commitment 2: Comparison of Outpatient Chemical Dependency Treatment Outcomes for Ethnic Specialty Providers versus Non-Specialty Providers

For this commitment, treatment retention rates of 90 or more days[12] and completion outcomes for Asian/Pacific Islander, American Indian/Alaskan Native, Hispanic/Latino, and Black individuals who were engaged in outpatient chemical dependency treatment during calendar year 2008, the most recent year for which there is complete data, were examined. Individuals who reported being a member of two or more races were counted in *each* ethnic group they identified. MHCADSD staff compared these outcomes for individuals enrolled in services at ethnic specialty provider agencies against the same results for individuals from each group enrolled at non-specialty provider agencies.

"Ethnic specialty providers" were defined based on the common community perception that an agency was a specialty provider for a specific population. Due to significant variance in the proportion of target clients being served by their perceived ethnic specialty providers, additional comparison analyses were run for some racial/ethnic groups. These looked at actual numbers and percentages of clients served by each agency, regardless of their community perception as a specialty or non-specialty provider.

In defining ethnic specialty providers, MHCADSD evaluators did not take into account agency structural factors, such as the percentage of agency staff or board members belonging to a particular ethnic group.

Outpatient chemical dependency treatment data is entered into a state-managed database. How this data is reported and managed is determined by the state, not by the county. It should be noted that a significant number of individuals in all categories were excluded from the treatment completion analysis because their exit reasons fell into categories[13] that the Washington State Division of Behavioral Health and Recovery excludes from treatment and completion analysis.

This analysis is consistent with practice statewide. MHCADSD believe that exit reason documentation and management merits further discussion, both internally and with the state.

[12] This treatment retention threshold is the standard used by the State to assess all substance abuse treatment providers. There is also a strong evidence base showing that individuals who actively participate in treatment for at least 90 days have better long-term sobriety success than those who receive fewer than 90 days of treatment.

[13] Per DSHS guidelines, the exit reasons from chemical dependency treatment completion deemed excludable from analysis are: 1) Died; 2) Moved; 3) Incarcerated; 4) Left with program advice; 5) Inappropriate admission; and 6) Charitable choice (transfer to faith-based services).

FINDINGS

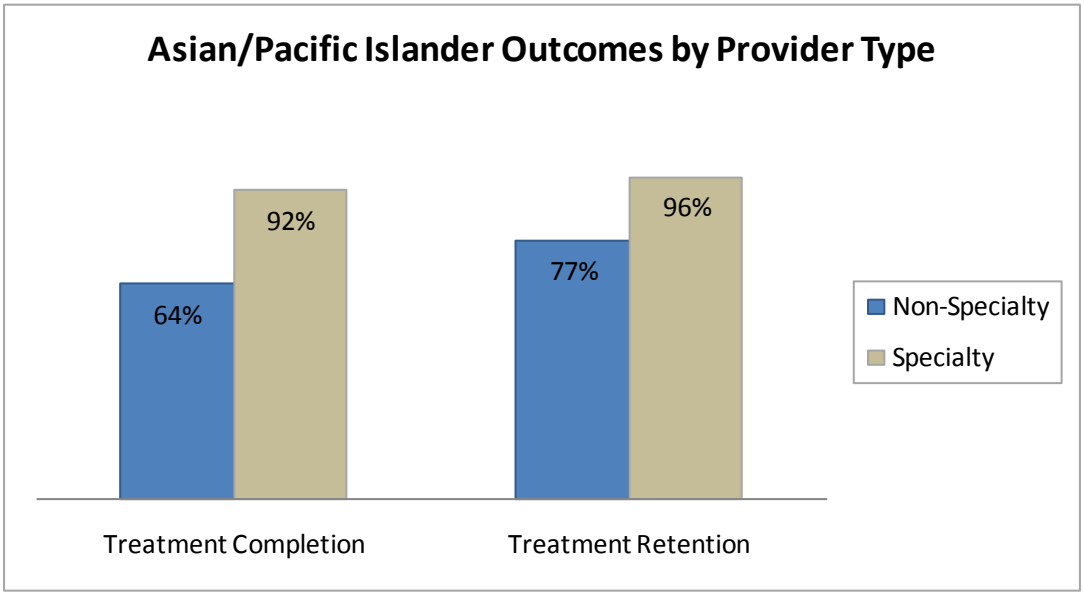
Overall, the results for both retention and completion for Asians/Pacific Islanders and Hispanics/Latinos were significantly better for the specialty provider agencies than the non-specialty agencies. Also, treatment retention was better for American Indians/Alaskan Natives at one specialty provider agency. Based on service population size or percentage, there is no true specialty provider for the Black population. Each of these groups will be discussed in detail below.

Asians/Pacific Islanders

For Asians/Pacific Islanders, a total of 503 individuals received outpatient chemical dependency treatment in 2008, with 208 individuals receiving treatment from an Asian/Pacific Islander specialty provider and 295 individuals from non-specialty provider agencies.

Asians/Pacific Islanders comprised 61 percent of the service population at the specialty agency. They received services at 17 additional non-specialty provider sites, eight of which served five or fewer Asian/Pacific Islander clients. About a third of the population sample (175 people) was excluded from the analysis for reasons noted above. The exclusion was proportionally equivalent between both groups.

Of the 328 persons who were included in the analysis, the group served by an Asian/Pacific Islander specialty provider did significantly better ($p<.0001$)[14] than those served by non-specialty providers. Completion rates were 92 percent for the specialty provider and 64 percent for the other providers. Treatment retention rates were 96 percent for the specialty provider and 77 percent overall for the other providers.



[14] 'P' refers to 'probability.' A measure of $p<.0001$ means that the probability that this result is due to chance alone is one in ten thousand (e.g. virtually unlikely).

American Indians/Alaskan Natives

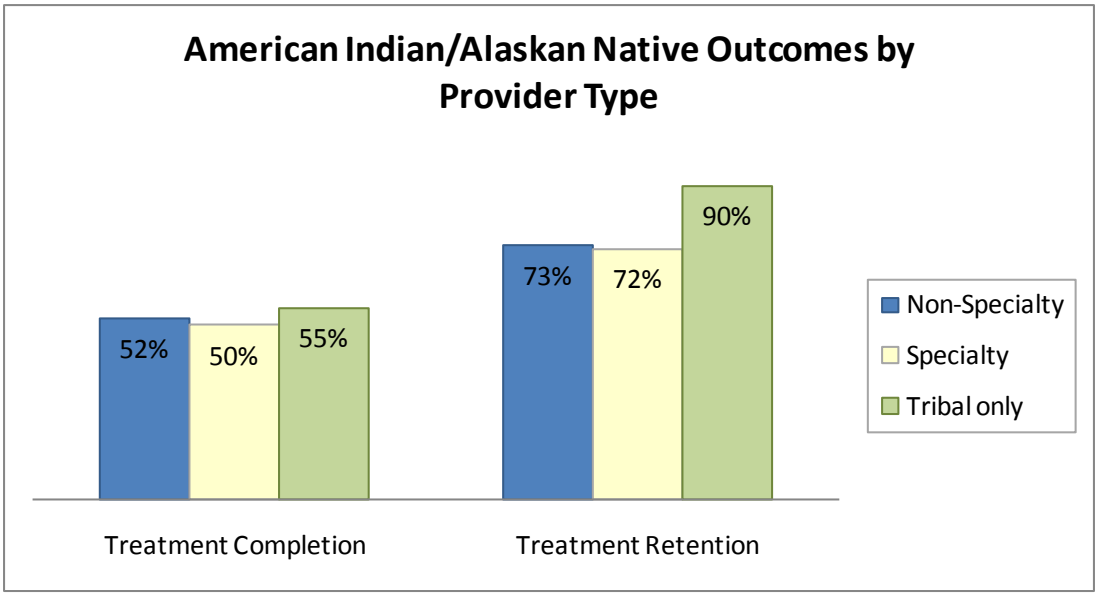
For American Indians/Alaskan Natives, a total of 524 individuals received outpatient chemical dependency treatment in 2008, with 137 individuals receiving treatment from three specialty providers and 387 individuals from non-specialty provider agencies.

American Indians/Alaskan Natives comprised 90 percent of the service population at a single tribal specialty agency and 18 percent of the service population at a regional agency, serving a broader urban population. Both agencies serve very different populations and employ different treatment models. The third specialty agency served only five American Indians/Alaskan Natives, who comprised 23 percent of their chemical dependency client population. American Indians/Alaskan Natives received services at 25 additional non-specialty provider sites, nine of whom served five or fewer American Indian/Alaskan Native clients.

Two hundred and seven people (39.5 percent of the sample) were excluded from the analysis for reasons noted above. Interestingly, nearly half (48 percent) of the American Indian/Alaskan Native population served by non-specialty providers needed to be excluded from analysis because of their exit reasons, whereas only 16 percent of those served by specialty providers were excluded.

Completion and retention rates were roughly equivalent between specialty and non-specialty providers. Completion rates were 50 percent for the specialty providers and 52 percent for the other providers. Treatment retention rates of 90+ days were 72 percent for the specialty provider and 73 percent overall for the other providers. However, because of the difference in exclusion rates noted above, 40 percent of all American Indian/Alaskan Native clients starting treatment at the specialty providers completed treatment compared to 25 percent of this population for non-specialty providers and 43 percent for the tribal provider.

It should be noted that there were significant differences between the specialty providers in retention outcomes. The specialty provider whose client population was 90 percent American Indian/Alaskan Native had a treatment retention rate of 90 percent, while the specialty provider whose American Indian/Alaskan Native client population was only 18 percent of their caseload had a retention rate of just 46 percent. Individuals served by the tribal provider did significantly better on treatment retention than those served by non-specialty providers.



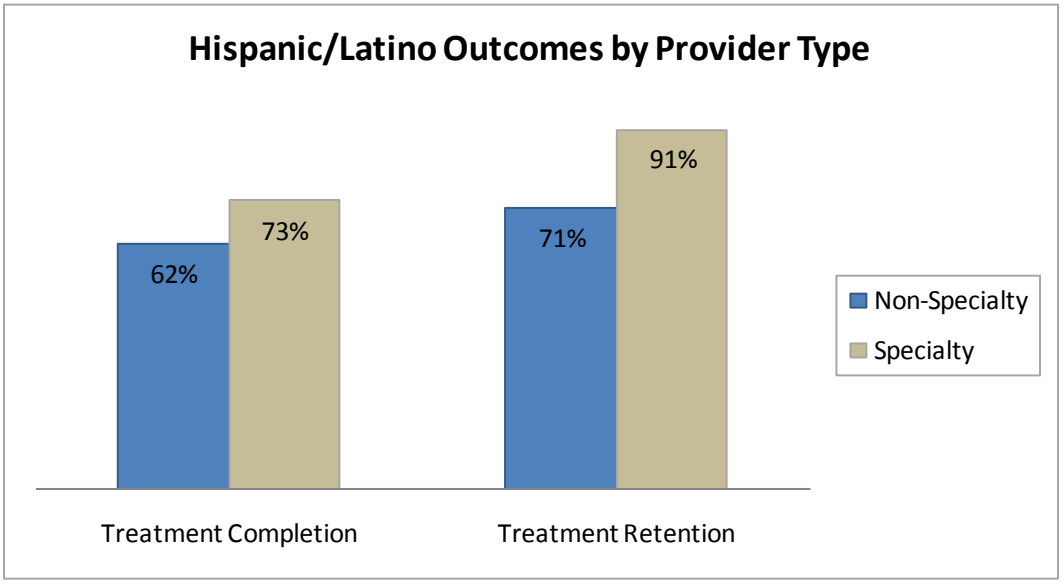
Hispanics/Latinos

For Hispanics/Latinos, a total of 698 individuals received outpatient chemical dependency treatment in 2008, with 254 individuals receiving treatment from a Hispanic/Latino specialty provider and 444 individuals from non-specialty provider agencies.

Hispanics/Latinos comprised 97 percent of the service population at the specialty agency. They received services at 28 additional non-specialty provider sites, eight of which served five or fewer Hispanic/Latino clients.

Just over a third of the population sample (240 people) was excluded from the analysis for reasons noted above. The exclusion rates were 41 percent for the non-specialty providers and 31 percent for the specialty provider.

Of the 422 persons who were included in the analysis, the group served by a Hispanic/Latino specialty provider did significantly better ($p<.0001$) than those served by non-specialty providers. Completion rates were 73 percent for the specialty provider and 62 percent for the other providers. Treatment retention rates were 91 percent for the specialty provider and 71 percent overall for the other providers.



Blacks

For Blacks, a total of 2,154 individuals received outpatient chemical dependency treatment in 2008. There is no true specialty provider for this population. One agency is commonly perceived as a specialty provider for this group. However, this provider served smaller numbers of Blacks than a number of other agencies. Also, only one of this agency's sites served a significantly higher percentage of Blacks than the larger treatment sites. Blacks accessed treatment at 36 treatment sites, with 11 sites serving five or fewer Black clients.

Treatment completion rates ranged from 33 to 95 percent and treatment retention ranged from eight to 96 percent. The program with the lowest 90 day retention had the highest treatment completion rate, indicating that it is a short term program not designed for longer retention.

There were no patterns of completion or retention for this population related to numbers or percentage of agency clients served. A total of 977 individuals, or 45 percent of this population was excluded from the analysis because of their exit reason classification.

Discussion

This analysis led to the identification of a number of issues that could benefit from further exploration. They include the following:

- How can exit reason reporting be improved so that it is meaningful for a greater proportion of the population served?
- What are the factors that contribute to differential rates of excludable exit reasons?
- How are coding factors contributing to the exclusion rates?
- To what extent, if any, does an agency's serving a minimum absolute number of individuals or percentage of agency client population from a particular racial/ethnic group affect treatment outcomes for that group?
- What structural factors (transportation, childcare, ethnic congruency between provider/client population, service hours, etc.) affect treatment outcomes?
- What differences in treatment models contribute to treatment outcomes?
- What external factors (community cohesiveness, urban vs. rural, etc.) affect treatment outcomes?
- What client factors (addiction severity, concurrent mental illness, incarceration history, etc.) affect treatment outcomes?

Commitment 3: Metabolic Syndrome in Mental Health Clients on Atypical Antipsychotics

Individuals with mental illness tend to die, on average, about 25 years younger than the general population. Multiple factors contribute to this disparity. One of these factors is a metabolic syndrome that is characterized by high lipid (e.g. fat) levels, obesity (as demonstrated by high Body Mass Index ratios), hypertension, and diabetes. Individuals who are on "atypical" antipsychotic medications are at particular risk for this syndrome.

For this commitment, MHCADSD conducted a prevalence assessment to determine if there are any racial/ethnic differences in the rates of metabolic syndrome among those receiving atypical antipsychotic medication. This research also explored whether there were any underlying modifiable structural or institutional factors that might be contributing to this disparity.

This analysis was done on a sample 819 individuals with metabolic syndrome identified at contracted outpatient mental health provider agencies.

The analysis found Blacks tended to trend toward higher prevalence of hypertension compared to Whites or Asians/Pacific Islanders. Blacks also were more likely to have higher diabetes levels than Whites. However, these differences were not statistically significant.

The only difference that reached statistical significance was weight. Asians/Pacific Islanders were statistically less likely than Whites ($p<.01$) or Blacks ($p=.01$) to be overweight. Also, Whites were statistically less likely to be overweight than Blacks ($p=.01$). These differences are actually smaller than in the general population, where, according to the 2009 Centers for Disease Control Health Interview Survey, Whites are three times as likely as Asians to be obese, and Blacks three to four times as likely.[15]

Based on MHCADSD's analysis, the true disparity is not between ethnic groups who suffer from mental illness. The disparity is in the overall rate of metabolic syndrome in this population compared to the general population, with obesity and other metabolic syndrome indicators occurring at roughly triple their typical prevalence rates. MHCADSD has an initiative underway to improve metabolic outcomes for these patients. All contracted mental health agencies have developed intervention plans to improve primary care linkage or to offer on-site wellness programs to address this issue.

Discussion

Based on this analysis, no actions over and above the planned interventions are needed to address racial or ethnic difference in this area.

Commitment 4: Work Closely With Other Divisions to Ensure Evaluation Efforts Are As Coordinated and Efficient As Possible.

MHCADSD has worked with evaluators in CSD to share data and evaluation approaches as appropriate. They are also coordinating with DDD on an evaluation of a substance abuse treatment program targeted toward individuals with cognitive disabilities.

[15] Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2009 Series 10: No. 249, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Disease Control and Prevention , National Center for Health Statistics August 2010, DHHS Publication No. (PHS) 2011-1577.

DEVELOPMENTAL DISABILIITIES DIVISION (DDD) 2010 ESJI COMMITMENTS AND FINDINGS

DDD agreed in 2010 to the following ESJI commitments:

Commitment 1- Update Parity Analyses of Birth-to-Three Early Intervention Services Enrollment Rates – Replicate previous years' analyses of enrollment rates for King County Birth-to-Three early intervention services across racial/ethnic groups.

Commitment 2- Analyze Outcomes for Birth-to-Three Clients – Replicate December 2009 analysis of early intervention outcomes across racial/ethnic groups.

Commitment 3 – Conduct an Evaluation of the 2009 Early Intervention Pilot Project – Assess the outcomes of SOAR's[16] early intervention outreach pilot with Hispanic/Latino, Somali, and Vietnamese communities. Also, develop recommendations regarding continued outreach to these communities and future outreach to other underserved groups.

Commitment 4– Assess Changes in Early Intervention Enrollment Rates for Hispanic/Latino, Somali, and Vietnamese communities - Work with early intervention providers to determine potential methods to involve them in reporting and analyzing changes in Hispanic/Latino, Somali, and Vietnamese enrollment in early intervention services.

Commitment 5 – Provide Networking/Training Events for Early Intervention Providers Serving Underrepresented Communities – Conduct networking/training events for community-based organizations, community liaisons, and community early intervention providers serving unique cultural and linguistic communities. Also, establish a community liaison network, which early intervention providers may utilize in their work with non-English speaking families.

Commitment 6- Alignment of Early Intervention Pilot Project with DDD Strategic Plan – Replicate previous year's work to ensure that early intervention pilot project aligns with priorities in DDD's strategic plan developed for implementation in July 2010.

Commitment 7– Department-wide Commitment – Continue to work closely with other divisions to ensure evaluation efforts are as coordinated and efficient as possible.

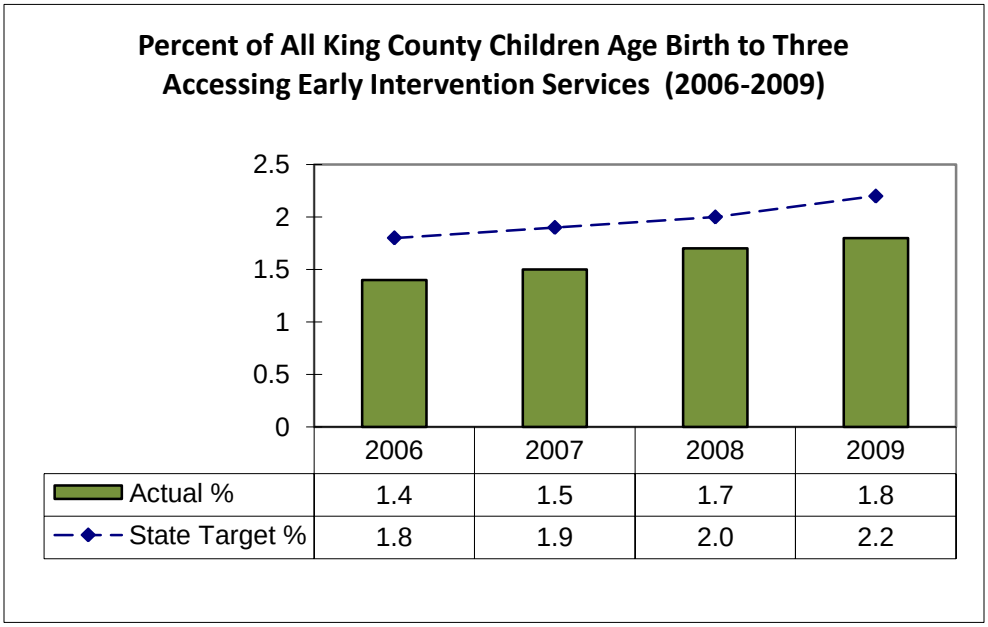
Commitment 1: Update Parity Analysis on Birth-to-Three Early Intervention Enrollment Rates

Early intervention (EI) services for infants with developmental delays are offered to all children nationally, regardless of their economic status. DDD is required by its receipt of federal funding for its Birth-to-Three early intervention program to serve a certain percentage of all children age birth to three. The state has set this benchmark at 2.3 percent[17].

[16] SOAR is a community coalition that advances the healthy development of children, youth & families in King County. It builds and strengthens effective partnerships and aligns community strategies to support children and youth (birth-18).

[17] In federal fiscal year 2008, Washington State reported 1.9 percent of children 0-3 in early intervention services, ranking Washington State 0.76 percent below the national averages of 2.66 percent. Despite increased emphasis on services to the very young (0-12 months), Washington state had 0.46 percent of these children in services, and ranked 48th among the 50 states and territories with similar eligibility criteria.

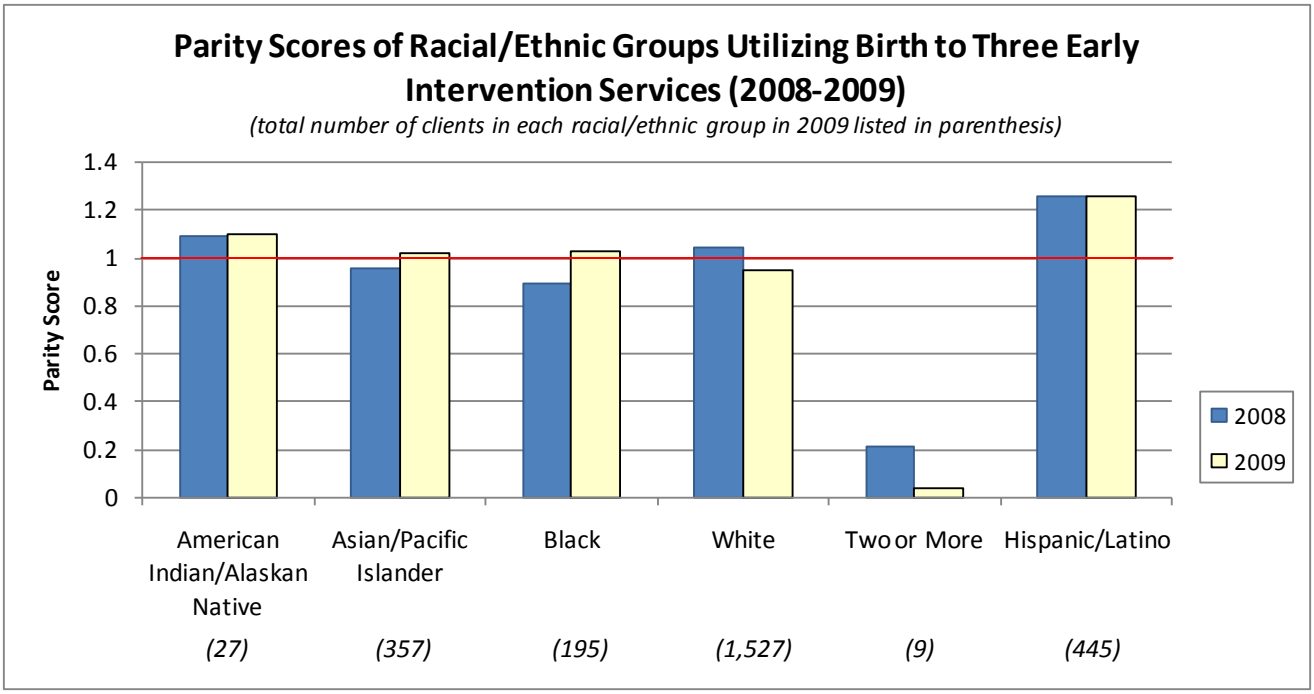
As shown in the graph below, DDD has almost met the state target for early intervention enrollment in each of the last four years.



Service Parity Across Racial/Ethnic Groups

Similar to its previous years' findings, nearly all racial/ethnic groups achieved parity in accessing DDD's early intervention services in 2009.

- Children identified as "Two or More" – those who are of mixed race/ethnicity – appear to be significantly underrepresented. However, the numbers for this group may be influenced by data reporting anomalies.



Note: Parity = 1.0 indicates a population is proportionately represented

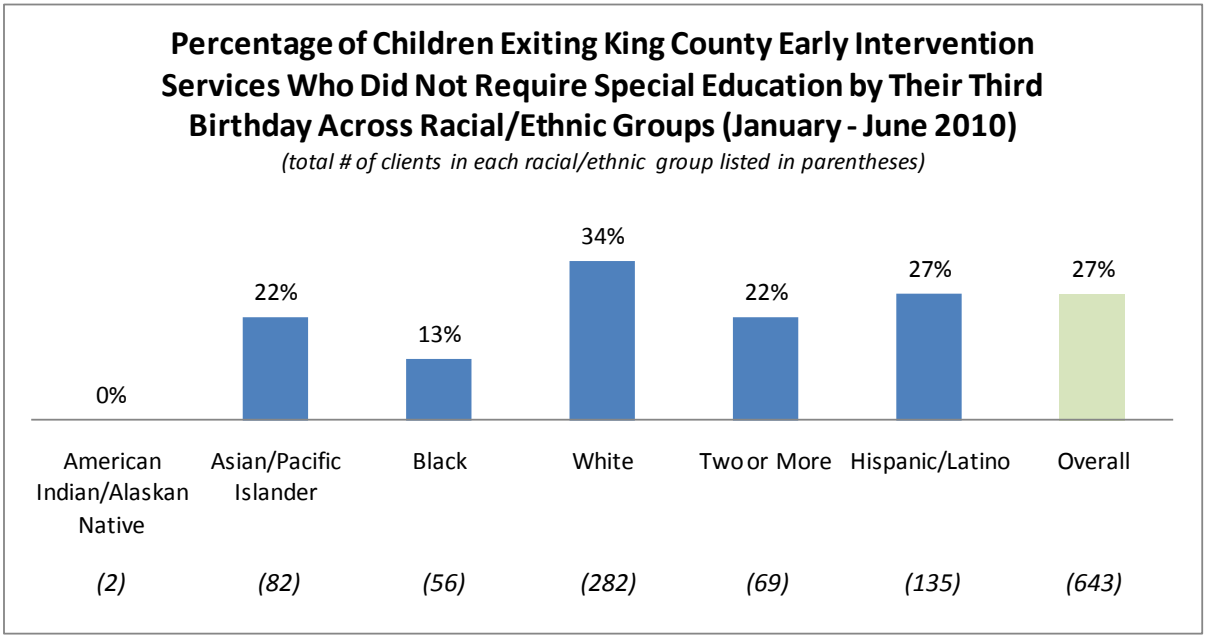
	2008 King County Population Birth to Four Years Old		2008 DDD Birth-to-Three Children Served			2009 DDD Birth-to-Three Children Served		
Race/Ethnicity	**All**	**% of Total**	**Number**	**% of Total**	**Parity**	**Number**	**% of Total**	**Parity**
American Indian/Alaskan Native	1,134	1	23	1.1	1.09	27	1.1	1.10
Asian/Pacific Islander	16,389	14.6	292	13.9	0.96	357	14.9	1.02
Black	8,872	7.9	149	7	0.89	195	8.1	1.03
White	75,736	67.2	1,469	70	1.04	1527	63.7	0.95
Two or More	10,520	9.3	38	2	.021	9	0.4	0.04
Unreported*			109	5	N/A	284	11.8	N/A
Total	**112,651**	**100**	**2,100**	**100**		**2399**	**100**	
Hispanic/Latino	14,131	12.5	333	15.9	1.26	445	15.8	1.26

*In 2010, the state changed its categorization of Hispanic/Latino from a race to that of an ethnicity. This caused some confusion in the reporting of client numbers to the state, resulting in the number of unreported children to double from 2008 to 2009. Technical assistance has been provided and unreported numbers should decrease to normal levels in future years.

Commitment 2- Analyze Outcomes for Birth-to-Three Clients

There is no national research or data that leads DDD to conclude that children of particular racial or ethnic populations in EI programs actually achieve higher or lower success rates.

The most recent King County-level data available on children exiting early intervention services shows that Whites were more likely than all other racial/ethnic groups to not require special education by their third birthday, though this difference is not statistically significant.



Total Children Exiting EI Services		Children Not Requiring Special Education by Their Third Birthday	
Race/Ethnicity	Number	Number	Percentage
American Indian/Alaskan Native	2	0	0
Asian/Pacific Islander	82	18	22
Black	56	7	13
White	282	96	34
Two or More	69	15	22
Unreported	17	3	18
Hispanic/Latino	135	37	27
Total	**643**	**176**	**27**

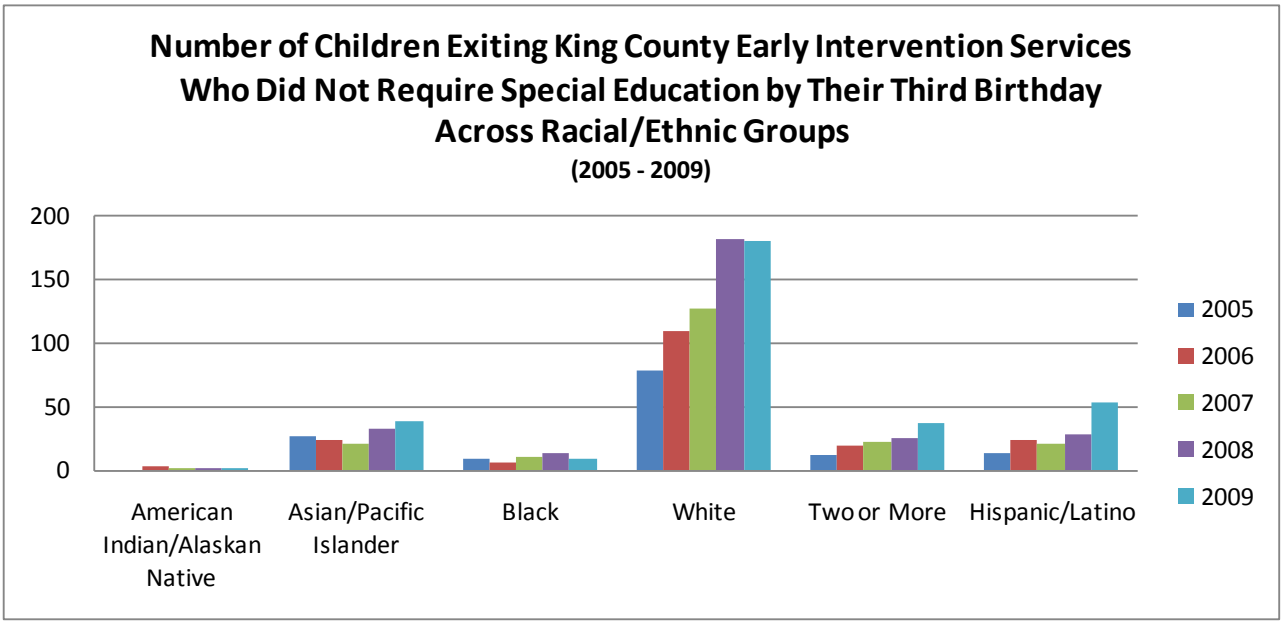
The above table illustrates that of the 643 children exiting EI services programs countywide, 176 children (27 percent overall), did not require special education by their third birthday at exit.

Because of small racial/ethnic group numbers available, a parity analysis is not provided. As in the access data presented earlier, when breaking down this outcome data into racial/ethnic groups, most groups are small (<30 individuals). Also, of the 176 who did not require special education by their third birthday,

18 children (over 15 percent) were identified as belonging to the category “Two or More”, or were shown in the database as “Unreported”. Any attempted analysis of these two categories would be distorted by possible reporting discrepancies.

Adding the non-White groups together into an aggregate “Of Color” group, 361 children Of Color exited services. Of these, 80 did not require special education by their third birthday at exit, or 22 percent of children Of Color exiting services. While this is lower than White alone, because of the small sample sizes it is not considered to be statistically significant.

In comparing the population of children served by DDD’s EI program from 2005 to 2009, it is evident that the number of children exiting services who did not require special education by their third birthday steadily increased for Asians/Pacific Islanders, Whites, and Hispanics/Latinos. For American Indians/Alaskan Natives and Blacks, the number of children in this same category stayed constant or dropped slightly.



Number of Children Exiting EI Services Who Do Not Require Special Education by Their Third Birthday	2005	2006	2007	2008	2009
American Indian/Alaskan Native	0	3	2	1	2
Asian/Pacific Islander	26	24	21	33	38
Black	9	6	11	14	9
White	78	110	127	182	180
Two or More	12	20	22	25	37
Unreported	5	10	5	9	11
Hispanic/Latino	14	24	21	28	53
Total	**144**	**197**	**209**	**292**	**330**

Commitment 3 – Conduct an Evaluation of the 2009 Early Intervention Pilot

Background

To improve upon historical program performance, in 2008 DDD worked with an Early Intervention Action Team of the King County Interagency Coordinating Council (KCICC) and established targeted outreach strategies for those racial/ethnic populations typically underserved, such as immigrant families for whom English is a second language.

The KCICC identified three separate populations to be targeted in an EI pilot program involving a grass-roots approach for engagement of new families: the Somali, Vietnamese, and Hispanic communities. To implement the pilot, DDD partnered with the SOAR early learning program to determine effective ways to reach out to these three different communities. DDD and SOAR co-hosted "Community Conversations" in the native language of the three target populations, providing information about family social services, including EI.

Through contacts made at the Community Conversations, fifteen bilingual, trusted individuals interested in becoming resources and community liaisons were identified and trained with materials DDD and SOAR developed. Each liaison was tasked to reach out to 20 families in their community – with an EI pilot program goal that 300 families be contacted in both 2008 and 2009. Interest in the information available allowed the pilot to exceed this goal and actually contact over 1,500 families during these two years.

Current EI Pilot Program Progress Report

Since 2009, SOAR and DDD have been contacting families who expressed concerns or were interested in obtaining additional information/support. This has been done to start the referral process with these families and ensure that appropriate connections were made.

For 2009, 562 additional families were reached, well above the goal of 300.

- Two hundred and sixty four Hispanic/Latino families were contacted, 50 of whom requested follow-up for early intervention enrollment.
- Two hundred Vietnamese families were reached. Of these, 30 asked for assistance in accessing early intervention services.
- Ninety-eight Somali families were contacted. Sixteen of these asked for follow-up on early intervention enrollment. In addition, outreach presentations were made to nine East African service/advocacy groups[18].

The pilot program's goals were to learn how many of the families contacted by community liaisons in 2008: 1) Applied to the EI program; 2) Were enrolled in and received services; and 3) Were satisfied with their contact, enrollment and service experience (the ultimate outcome goal).

[18] These were: Somali Bantu Association of Washington, Horn of Africa Services, Somali Community Services Coalition, Somali Community Services of Seattle, Somali National Development Program, East African Community Development Council, East African Community Services, Northwest Somali Community Center, Refugee Support Service Coalition, and Hope Academic Enrichment Center.

1) **Number of Families Who Applied To EI Program –** Out of the 96 families that requested follow up for services 38 has been referred on to staff with the Department of Social and Health/Services/Division of Developmental Disabilities (DSHS/DDD).

2) **Number of Children Enrolled in EI Service** – Due to confidentiality Issues, DDD was unable to obtain the number of families enrolled in early intervention services. DDD is currently working with SOAR and early intervention agencies to better track the number of children who enroll in services in 2011.

3) **Client Satisfaction with Service Experience** – According to surveys conducted by SOAR, families were very satisfied with their contact and service experience. Nonetheless, this evaluation showed that parents are still reluctant to call DDD and that the families need guidance during the process of getting services. Also, some families found the referral process too long and confusing in languages other than English. In addition, most affected families prefer private face-to-face meetings as their introduction to learning about developmental disabilities.

Commitment 4- Assessing Changes in Early Intervention Enrollment Rates for Somali, Vietnamese, and Hispanic communities

After analyzing data for 2008 and 2009, it has been established that the racial categories DDD uses to collect data are too broad, such as American Indian/Alaskan Native, Black, Asian/Pacific Islander, etc. These categories need to be broken down into smaller ethnic populations like Vietnamese and Somali. In 2011, DDD will work with EI providers to be more specific about children's ethnicity(ies) as they are enrolled into DDD programs.

Commitment 5 – Provide Networking/Training Events for Early Intervention Providers Serving Underrepresented Communities

In 2010, SOAR and DDD held five trainings for community liaisons. These focused on a variety of issues including an overview of the project and the developmental disabilities system, community outreach and leadership, and the program's reporting framework.

One of the Vietnamese community liaisons has been hired and placed at The Arc of King County. This will assist Vietnamese families as well as other providers to increase their understanding of how to access and influence the developmental disabilities system.

Commitment 6- Alignment of Early Intervention Pilot Project with DDD Service Plan – In July 2010, DDD revised its Plan for Developmental Disabilities Services 2010-2013. In doing so, it ensured that its early intervention pilot project is aligned with this plan's goals and strategies. Goal 1 of this revised plan is "*Families that have a child under age three with a developmental delay or disability access early intervention services in a timely manner*". Within this goal are strategies to continue outreach to cultural communities. It also calls for DDD to explore methods to improve outreach and access to supports in cultural communities including recruiting and training Parent Peer Educators from families who have participated in services and who are trained and supported to do "teach backs" to parents.

Commitment 7: Department-wide Commitment – DDD has worked other divisions as appropriate to share program data.

COMMUNITY SERVICES DIVISION (CSD) 2010 ESJI COMMITMENTS AND FINDINGS

CSD committed to the following ESJI research in 2010:

Commitment 1 – Analyze Accessibility of Homeless Services Across Racial/Ethnic Groups - Conduct ongoing monitoring of data for CSD-contracted homeless services, determining whether racial/ethnic parity levels in access remain constant.

Commitment 2 - Analyze Outcomes for Households Moving from Emergency Shelter to Transitional Housing or from Transitional to Permanent Housing- Replicate CSD's 2009 outcomes analysis with new and expanded Safe Harbors Homeless Management Information System (HMIS) [19] data. In doing so, verify whether the rate by which Hispanic/Latino families move from emergency shelter into transitional or permanent housing is lower than average, as was found in 2009.

Commitment 3 - Investigate Reasons for the Underrepresentation of Asians/Pacific Islanders Among Homeless Services Populations **–** Conduct interviews with stakeholders to determine if there are institutional barriers which limit Asian/Pacific Islander use of the homeless services system.

Commitment 4 - Support Improved Data Collection and the Coordination of Evaluation Efforts **–** Work with Safe Harbors HMIS staff to improve the consistency of agency participation and quality of data collected. This will increase the data's reliability. Also, work closely with other divisions to ensure evaluation efforts are as coordinated and efficient as possible.

Commitment 1 – Analyze Accessibility of Homeless Services Across Racial/Ethnic Groups

In September 2010, CSD replicated its 2009 analysis CSD-funded homeless services client utilization rates across racial/ethnic groups. The data was drawn from contracted agencies' 2010 King County demographic reports for winter and spring 2010. Due to timing, this analysis combined two quarters rather than three as in the prior years. Although the total number of clients reported is smaller based on two quarters, there is no evidence to suggest that this would undermine data comparability.

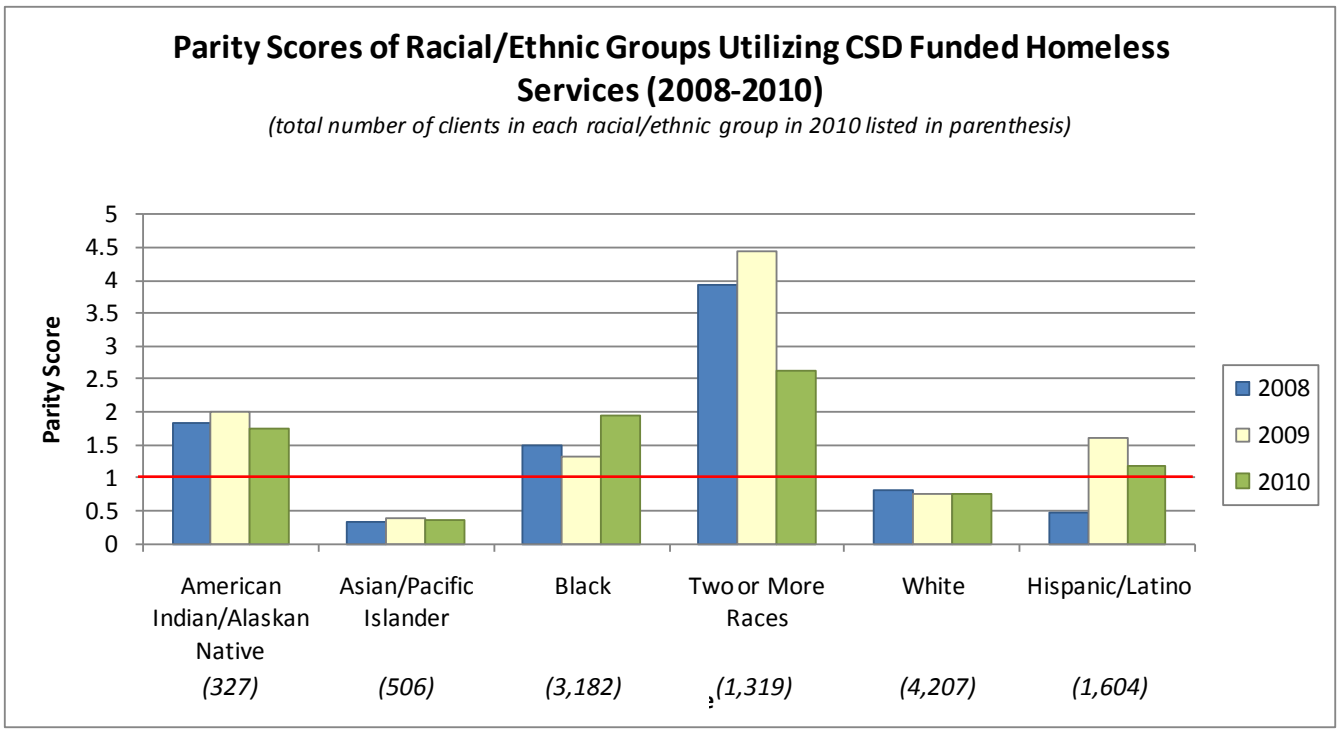
In general, results are consistent with those of the previous two years:

- Asians/Pacific Islanders, Whites, and American Indians/Alaskan Natives saw little change to their representation of CSD-funded homeless services clients; Asians/Pacific Islanders were quite underrepresented, Whites were slightly underrepresented, and American Indians/Alaskan Natives were well overrepresented.

- Hispanics/Latinos decreased in their percentage of CSD-contracted homeless service clients. They remain slightly overrepresented overall.

- Blacks increased in their overrepresentation among CSD-contracted homeless service clients. One explanation for this change may be the corresponding drop in the percentage of persons identifying as "Two or More Races" over the same period studied.

[19] Safe Harbors is King County's web-based Homeless Management Information System (HMIS) used to measure the extent of homelessness in our community. It was fully implemented in January 2007 and is being used in emergency shelters, transitional and permanent housing programs as well as supportive service and homeless prevention programs that receive public funding.



Note: Parity = 1.0 indicates a population is proportionately represented

	2007-2009 King County Population Living Below the Federal Poverty Level (<FPL)*		2008 CSD Homeless Services (First 3 Quarters)**			2009 CSD Homeless Services First 3 Quarters***			2010 CSD Homeless Services First 2 Quarters****		
	Number	Percent	Number	Percent	Parity	Number	Percent	Parity	Number	Percent	Parity
American Indian/Alaskan Native	3,224	1.9%	806	3.5%	1.8	1,029	3.8%	2.0	327	3.3%	1.7
Asian/Pacific Islander	24,498	14.2%	1,080	4.6%	0.3	1,462	5.4%	0.4	506	5.1%	0.4
Black	28,784	16.6%	5,841	25.0%	1.5	6,031	22.1%	1.3	3,182	32.4%	2.0
Two or More Races	8,758	5.1%	4,681	20.1%	3.9	6,187	22.7%	4.5	1,319	13.4%	2.6
Other	8,652	5.0%	159	0.7%	0.1	800	2.9%	0.6	271	2.8%	0.6
White	99,075	57.3%	10,730	46.1%	0.8	11,806	43.2%	0.8	4,207	42.9%	0.7
Total	172,991	100.0%	23,297	100.0%	1.0	27,315	100.0%	1.0	9,812	100.0%	1.0
Hispanic/Latino	23,757	13.7%	1,468	6.3%	0.5	6,016	22.0%	1.6	1,604	16.3%	1.2

Sources:
* 2007-2009 American Community Survey – Local data tables
** Community Services Division – Contractor provided Client Profile Reports 2008
*** Community Services Division – Contractor provided Client Profile Reports 2009
**** Community Services Division – Contractor provided Client Profile Reports 2010

Although findings have remained consistent over the last three years, it will be important to continue monitoring client access to services based upon contractors' reporting. However, it is time to focus on more discrete, qualitative investigations of specific sub-populations within the Black and Asian/Pacific Islander racial categories or broader ESJI issues such as the effect immigrant and refugee status has on service access.

Commitment 2 - Analyze Outcomes for Households Moving from Homeless to Permanent Housing

For its second ESJI commitment, CSD agreed to replicate its 2009 analysis of whether client transition rates in moving from emergency shelters or transitional housing to more stable housing differed across racial/ethnic groups. A primary purpose for conducting this analysis a second time was to determine whether the success rate for Hispanic/Latino families moving from emergency shelters to transitional or permanent housing continued to be statistically significantly below that of other racial groups, as was found in 2009.

CSD evaluators conducted this analysis using the same data source and methodology they utilized in 2009. Data was drawn from the Safe Harbors HMIS database. It was then cleaned and organized[20] by CSD evaluators into four cohorts based upon the type of homeless service and household. It should be noted that families were counted as a single unit to overcome the effect family size could have on findings.

Cohorts Used

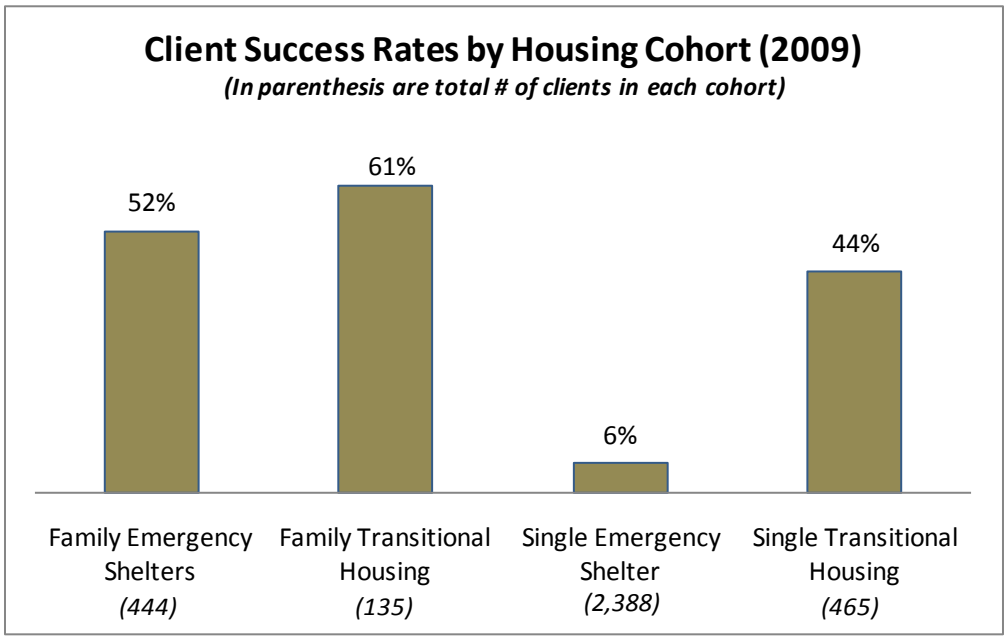
1. Family Emergency Shelters– 442 households
2. Family Transitional Housing - 135 households
3. Single Adult Emergency Shelters – 2,338 individuals
4. Single Adult Transitional Housing - 465 individuals

Criteria for Determining and Assigning "Successful" and "Non-Successful" Exits

Clients were assigned a code of "Successful" or "Non-Successful" depending upon what type of homeless services they were in initially. For emergency shelter clients, "success" was assigned if they completed the program and moved into transitional or permanent housing, or just moved into permanent housing. Likewise, transitional housing clients were "successful" if they completed the program and moved into permanent housing. An additional factor for both groups was whether they spent enough time in their respective housing program (14 days for emergency shelter clients or 30 days for transitional housing ones) to attribute success to the efforts of the program.

[20] The analysis started with over 23,000 service records which had been cleaned and de-identified by Safe Harbor's staff. CSD evaluation unit staff then refined and organized the data. Two data sets were created. The first was of 11,339 unduplicated clients for whom race could be identified. The second was an exit data set of 3,432 clients broken down into four cohorts, in accordance with client's exit results. Safe Harbors HMIS collects exit data including "Exit Date," "Reason for Leaving (the program)" and "Housing Moved To." Exit data was established for 3,432 individuals in the HMIS data set who had exited or moved to another service in the homeless service system. Exit data was included in the analysis of "success" when the client had race/ethnicity identified and the record included: (1) an exit date; (2) reason for leaving; and (3) housing moved to.

The rates shown on the following page are for this project only, based upon the sample of records available. Due to the substantial refinement of the data set and nature of data collection in Safe Harbors, these rates are not intended to reflect or be used as definitive success rates for the regional homeless service system.



ESJI Analysis Cohorts and Outcomes Categories		Non-Success	Success	Total
Family Emergency Shelters (Heads of Households)	Number	214	230	444
	%	48.2%	51.8%	100.0%
Family Transitional Housing (Heads of Households)	Number	53	82	135
	%	39.3%	60.7%	100.0%
Single Emergency Shelter	Number	2,256	132	2388
	%	94.5%	5.5%	100.0%
Single Transitional Housing	Number	259	206	465
	%	55.7%	44.3%	100.0%
Total	Number	2,782	650	3,432
	%	81.1%	18.9%	100.0%

Outcomes Analysis Across Racial/Ethnic Groups

Comparisons of client outcomes across racial/ethnic groups were completed for three of the cohorts: family emergency shelter, family transitional shelter, and single adult transitional housing. Like in last

year's analysis, the single adult emergency shelter data lacked enough complete exit data to conduct meaningful analysis[21].

Family Emergency Shelters

The family emergency shelter cohort was established as 444 heads of households. Of this total, 51.8 percent met the criteria of success.

Whites had a 50.5 percent success rate whereas People of Color were 52.1 percent successful. This difference was not statistically significant.

Family Emergency Shelter Success Rates Comparison		**Non-Success**	**Success**	**Total**
People of Color	Number	167	182	349
	%	47.9%	52.1%	100.0%
White	Number	47	48	95
	%	49.5%	50.5%	100.0%
Total	Number	214	230	444
	%	48.2%	51.8%	100.0%

Family Transitional Housing

The cohort was 148 heads of households who exited family transitional housing and had enough data for analysis. Overall, 61 percent of households were successful, the highest success rate of all cohorts.

People of Color had a 59.2 percent success rate and Whites were 64.9 percent successful. This difference was not statistically significant.

Family Transitional Housing Success Rates Comparison		**Non-Success**	**Success**	**Total**
People of Color	Number	40	58	98
	%	40.8%	59.2%	100.0%
White	Number	13	24	37
	%	35.1%	64.9%	100.0%
Total	Number	53	82	135
	%	39.3%	60.7%	100.0%

[21] The four cohorts were analyzed using Statistical Packages for the Social Sciences (SPSS). Descriptive frequency statistics and cross tabulations were the primary approach. Statistical significance was established using chi square where sample size was large enough.

Single Adult Emergency Shelters

As with year 2008 data, CSD researchers determined that there were not enough 2009 client exits from single adult emergency shelters that met the success criteria to conduct credible analysis. Although over 2,388 clients were designated as having "completed" the shelter program, in very few cases was there an identification of where the client moved to or known housing status.

Single Adult Transitional Housing

The analysis cohort had 465 unique individuals. Of these, 206 met the success criteria (44.3 percent).

There was no statistically significant difference between "success" rates for People of Color (47.5 percent) and Whites (41.3 percent).

Single Transitional Housing Success Rates Comparison		**Non-Success**	**Success**	**Total**
People of Color	Number	117	106	223
	%	52.5%	47.5%	100.0%
White	Number	142	100	242
	%	58.7%	41.3%	100.0%
Total	Number	259	206	465
	%	55.7%	44.3%	100.0%

Analysis of Success Rates Based on Specific Client Race/Ethnicity

After the review of broader categories such as "People of Color", the analysis effort broke down the data on race/ethnicity into the Census racial categories as well as the ethnicity of Hispanic/Latino and assessed comparative differences. In this same analysis conducted the previous year, the single significant finding[22] was that the success rate of Hispanics/Latinos in the family emergency shelter cohort was lower than that of any other race/ethnicity in this same cohort for whom there were enough clients to conduct reliable analysis.

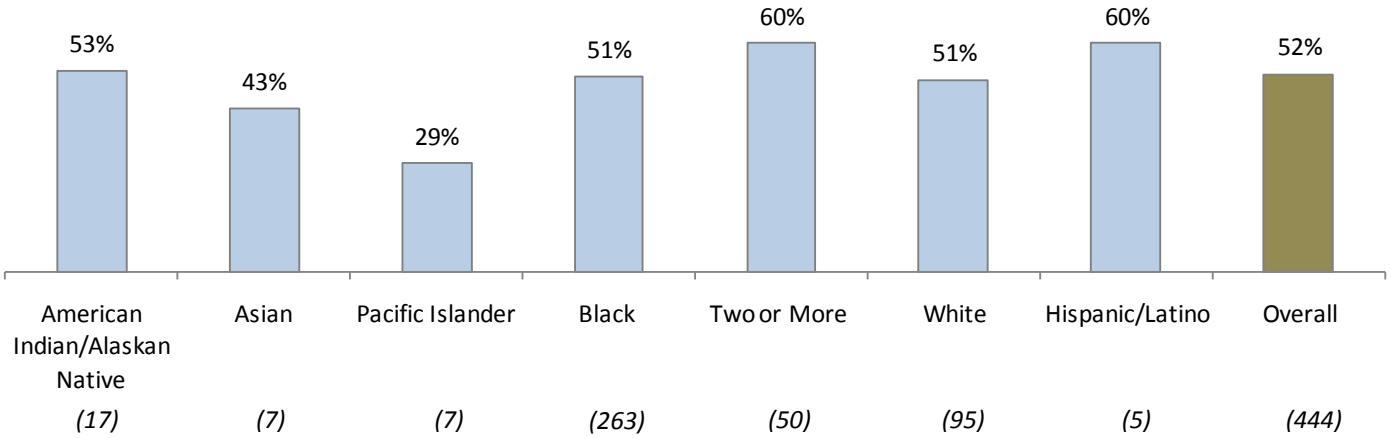
The current analysis of success rates showed no statistically significant differences for clients in those racial/ethnic categories with more than five persons/households. The low-success rate found for Hispanics/Latinos in the previous year's analysis was not replicated, as their success was comparable to other groups.

Findings for all racial/ethnic groups except Blacks and Whites should be interpreted with caution for all cohorts save Single Adult Emergency Shelter. Small numbers of persons/households (< 30) from the other racial/ethnic groups were in the other three cohorts.

[22] The method used to determine statistical significance was chi square analysis.

Family Emergency Shelter Success Rates Across Racial/Ethnic Groups *(2009)*

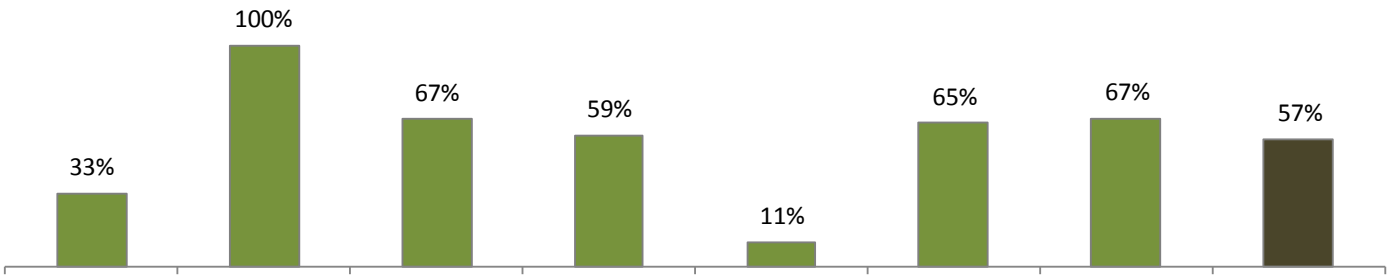
(total number of households in each racial/ethnic group listed in parenthesis)



American Indian/Alaskan Native	Asian	Pacific Islander	Black	Two or More	White	Hispanic/Latino	Overall
(17)	*(7)*	*(7)*	*(263)*	*(50)*	*(95)*	*(5)*	*(444)*

Family Transitional Housing Success Rates Across Racial/Ethnic Groups *(2009)*

(total number of households in each racial/ethnic group listed in parenthesis)

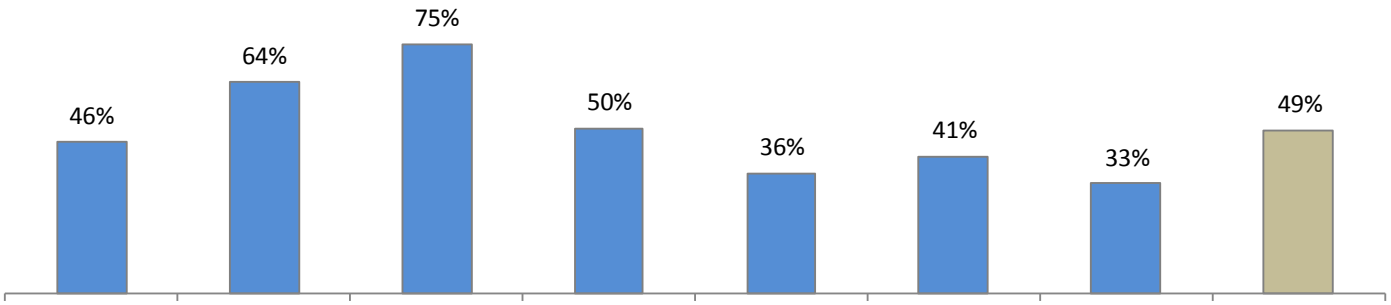


American Indian/Alaskan Native	Asian	Pacific Islander	Black	Two or More	White	Hispanic/Latino	Overall
(6)	*(2)*	*(3)*	*(71)*	*(13)*	*(37)*	*(3)*	*(135)*

Single Adult Transitional Housing Success Rates Across Racial/Ethnic Groups

(2009)

(total number of households in each racial/ethnic group listed in parenthesis)



American Indian/Alaskan Native	Asian	Pacific Islander	Black	Two or More	White	Hispanic/Latino	Overall
(22)	*(11)*	*(4)*	*(143)*	*(36)*	*(243)*	*(6)*	*(440)*

Race/Ethnicity Identified 2009 Emergency Shelter and Transitional Housing Clients		Family Emergency Shelter	Family Transitional Housing	Single Adult Emergency Shelter	Single Adult Transitional Housing
American Indian/Alaskan Native	Total households/ individuals	17	6	82	22
	% successful	52.9%	33.3%	1.2%	45.5%
Asian	Total households/ individuals	7	2	54	11
	% successful	42.9%	100%	1.9%	63.6%
Pacific Islander	Total households/ individuals	7	3	42	4
	% successful	28.6%	66.7%	14.3%	75.0%
Black	Total households/ individuals	263	71	928	143
	% successful	51.3%	59.25%	5.3%	49.7%
Two or More (including Hispanic/Latino and Other race)	Total households/ individuals	50	13	84	36
	% successful	60.0%	11.3%	11.9%	36.1%
White	Total households/ individuals	95	37	929	243
	% successful	50.5%	64.9%	6.6%	41.2%
Hispanic/Latino	Total households/ individuals	5	3	269	6
	% successful	60.0%	66.7%	1.5%	33.3%
Total clients	Total households/ individuals	444	135	2388	440
	% successful	51.8%	60.7%	5.5%	44.3%

Conclusions – Outcomes Analysis

The overall findings from 2008 were replicated and there appears to be no inherent, statistically verifiable difference in success rates based upon client ethnicity or race. Hispanics/Latinos succeed in rates commensurate with those of other ethnicities/races in each cohort. Clearly, race and ethnicity does not play a measurable factor in determining a household's success in King County's homeless services system.

We continue to need greater accuracy and consistency in the HMIS data collection system – especially regarding exit and outcomes measurement.

Commitment 3 - Investigation of Reasons for the Underrepresentation of Asians/Pacific Islanders in Homeless Services System

Background

The above-presented data on CSD-funded homeless services providers shows that Asians/Pacific Islanders[23] have consistently been underrepresented among CSD-funded homeless services clients. To

[23] In analyzing data on Asian/Pacific Islander's utilization of homeless services, it is important to remember the diversity of languages, cultures and experiences contained in this category. Within it are 43 different ethnic

determine the underlying reasons for this phenomenon, CSD researchers further investigated this issue, both quantitatively and qualitatively.

Analysis Approach

To confirm the above findings, CSD evaluators reviewed other homeless services system data sources. These were the One Night Count shelter survey[24], a City of Seattle street survey and Safe Harbors HMIS. Also, to better understand the reasons for Asian/Pacific Islander's underrepresentation amongst homeless services clients, a CSD evaluator performed a national literature review. In addition, CSD conducted stakeholder interviews with staff at the sole provider of homeless services dedicated to Asians/Pacific Islanders, Asian Counseling and Referral Services (ACRS).

Data Analysis – Asian/Pacific Islander Utilization of King County Homeless Services System

Other local data sources show similar percentages of Asians/Pacific Islanders accessing the homeless services system as found for CSD's contracted homeless services providers.

- Based on 2010 Safe Harbors HMIS data, Asians/Pacific Islanders comprised 3.9 percent of homeless services clients. In comparison, they made up 5.1 percent of homeless services clients reported by CSD's contracted providers.

- In the 2010 One Night Count shelter survey, Asians/Pacific Islanders comprised four percent of clients in emergency shelter and transitional programs.[25]

- A 2009 City of Seattle survey of unsheltered homeless persons showed that three percent of those surveyed identified as Asian.[26]

2009 Emergency Shelter and Transitional Housing Clients (*with race/ethnicity identified in HMIS*)	**Family Emergency Shelter**	**Family Transitional Housing**	**Single Adult Emergency Shelter**	**Single Adult Transitional Housing**	**Total**
Asian	**41**	**28**	**144**	**27**	**240**
	2.1%	**1.9%**	**2.2%**	**2.1%**	**2.1%**
Pacific Islander	**63**	**37**	**92**	**12**	**204**
	3.2%	**2.5%**	**1.4%**	**1.0%**	**1.8%**
Total Clients – all races	**1556**	**1181**	**7192**	**941**	**10870**
	100.0%	**100.0%**	**100.0%**	**100.0%**	**100.0%**

subgroups. By aggregating all Asian/Pacific Islander groups into one category, it is possible that meaningful differences in access to services are obscured for subpopulations, like recent immigrants or refugees.

[24] This is a survey of clients staying at all emergency shelters and transitional housing programs during the same 24-hour period.

[25] *2010 One Night Count Survey Data. Available at* *http://www.kingcounty.gov/socialservices/Housing/PlansAndReports/HCD_Reports.aspx*

[26] *Seattle Homeless Needs Assessment, October 2009. Available at* *http://www.seattle.gov/housing/homeless/HNA_report_11-09.pdf*

Discussion – Why Asians/Pacific Islanders Are Underrepresented Among Populations Experiencing Homelessness

To better understand the underrepresentation of Asians/Pacific Islanders among those experiencing homelessness, interviews were conducted with service providers and stakeholders in September 2010. In addition, a thorough literature review was undertaken. Based upon this research, the following three reasons were found to be of key importance in Asian/Pacific Islander underrepresentation among clients seeking homelessness services:

1) Asians/Pacific Islanders Are More Likely to Rely on Family/Friends During Housing and/or Economic Crises; and
2) Barriers to the Homeless Services System Are Intensified by Language and Cultural Issues.

Asians/Pacific Islanders Are More Likely to Rely on Family/Friends During Housing and/or Economic Crises

All stakeholder interviews, data search, and literature reviews confirmed the common perception that doubling up with other families or like community members is a very heavily relied upon strategy to cope with a housing crisis in Asian/Pacific Islander communities. Partly owing to this, Asians/Pacific Islanders do not seek services as often as other groups in the mainstream homeless services system, the source of almost all data on homeless client demographics. Given the narrow federal definition of homelessness[27], persons living doubled up also are often not described as being "at-risk" of homelessness.

"Asians tend to be highly group-oriented people who place a strong emphasis on family connection as the major source of identity and protection against the hardships of life."[28] In an interview with ACRS' Behavioral Health Team and housing coordinator, CSD evaluators confirmed that it is the norm for community members to take care of one another, receiving individuals and even entire families into their home and sharing resources.

This norm often works well, and can result in tightly knit, supportive families and communities. But there are a number of serious problems when overcrowding becomes severe. ACRS staff said they see households with very high housing cost burdens, where rent is at 80, 90 or even 100 percent of income, so doubling or tripling up is the result. Staff mentioned a case where a group of 12 recently-arrived Bhutanese refugees are living in a one-bedroom apartment.

"Among racial and ethnic groups, Hispanic/Latino and Asian households have the highest incidences of overcrowding. As might be expected, recent immigrants among these groups have the highest overcrowding rates of all. However, even the US-born members of these two ethnic groups have

[27] The current federal definition of homelessness is limited to people who are on the streets or who are staying in shelters. It excludes people who are forced to live in other situations, including people staying with others temporarily because they have nowhere else to go (e.g. "doubled-up"), and people staying in motels due to lack of adequate alternatives.

[28] *Carteret, Marcia 2009. Cultural Values of Asian Patients & Families. Available at http://www.dimensionsofculture.com/home/cultural_values_of_asian_patients_families*

proportionally much higher levels of overcrowding than do their US-born counterparts among Black or White households.[29]

When providing accommodations to others, oftentimes the host family's housing is jeopardized if landlords learn that lease terms have been violated. For those landlords willing to tolerate overcrowding, families often lose their ability to complain about safety violations, mold or unfair landlord practices. This can result in unsafe and unsanitary living conditions.

Barriers to the Homeless Services System Are Intensified by Language and Cultural Issues

The homelessness system has barriers to entry that are encountered by all service seekers. These include:

- Clients' lack of familiarity with what services are available or how to access them;
- Long wait times for gaining access to a program; and
- Clients experiencing multiple relocations between programs, often requiring them to move away from familiar neighborhoods.

These challenges are compounded for many Asians/Pacific Islanders due to language and cultural issues. Among these are:

- Asians/Pacific Islanders may have difficulty accessing homeless services because of their limited English skills or the lack of services in their native language.
- Accessing shelter is seen as dangerous and undesirable. As a result, many individuals instead stay on the streets or "in the jungle" (under Interstate 5).
- Geography of where services and housing are located is even more important for these populations. Refugees in particular benefit from staying close to other families in similar circumstances.
- For some families, their family size is a barrier due to lack of larger units in the transitional housing and emergency shelter system.
- Families are often split up in order to access shelter services. This is unacceptable for most Asian/Pacific Islander families.

The above-mentioned case of a recently arrived Bhutanese refugee family living 12 persons to a one bedroom apartment illustrates these barriers. The household has refused to be relocated outside of the area where they are living because they would lose their community supports (e.g. connection with their fellow refugees) and familiarity with neighborhood shops and community services.

[29] *Dowell Myers and Baer, William C., Choi, Seong-Youn 1996. The changing problem of overcrowded housing. Journal of the American Planning Association. , v. 62 (Winter '96) p. 66-84*
Available at http://www-bcf.usc.edu/~dowell/pdf/changi.pdf

Emerging Issue: Immigrant and Refugee Status

According to the federal Substance Abuse and Mental Health Services Administration (SAMHSA), Asian/Pacific Islanders are not overrepresented among other high-need, vulnerable populations such as those who are incarcerated or have substance abuse problems. However, Asians/Pacific Islanders are heavily represented among refugees. Many Southeast Asian refugees are at risk for post-traumatic stress disorder (PTSD) associated with trauma experienced before and after immigration to the U.S. One study found that 70 percent of Southeast Asian refugees receiving mental health care met diagnostic criteria for PTSD.[30]

In King County, refugee and immigrant families of all ethnicities are being seen in increasing numbers by homeless services providers. They have many issues that affect their housing stability, including limited English proficiency and formal education, lack of documentation, and medical issues. In addition, the eligibility criteria for most subsidized housing programs prevent undocumented families from accessing housing assistance.

Recommendations

1) *Improve Service Access for Immigrants and Refugees* – A natural fit for these populations are cultural navigators/advocates. These are bi-lingual and bi-cultural persons who help clients learn where to turn to access new systems. It is important that such navigators advocate for refugee clients to receive all the mainstream entitlements. Asian and Pacific Islander immigrants and refugees face the same barriers as other populations, and would benefit from help navigating the system.

   These programs' services should be tailored to meeting immigrant and refugee needs, with attention to issues of trauma and PTSD.

2) *Develop Interventions that Address the Housing Issues Experienced by Asians/Pacific Islanders and Other Groups Less Likely to Seek Homeless Services* – There should be an additional emphasis on outreach to Asian/ Pacific Islander communities by programs offering assistance on landlord/tenant relationships and housing repair since this population is more likely to double up or live in overcrowded housing.

3) *Support the Cultural Competency of Housing and Support Service Providers* - Continue to support training for provider agency staff on cultural competency. Also, reward agency provision of services in multiple languages and other forms of cultural capacity.

4) *Ensure That the Coming Improvements to the System Benefit All Groups, Including Asians/Pacific Islanders* - With the passage of the Homeless Emergency and Rapid Transition to Housing (HEARTH) Act of 2009[31] and as the homelessness services community continues to learn and

[30] *SAMHSA 2007. Mental Health: Culture, Race, Ethnicity - Fact Sheets, Available at http://mentalhealth.samhsa.gov/cre/fact2.asp*

[31] The HEARTH Act amends and reauthorizes the McKinney-Vento Homeless Assistance Act with substantial changes, including: 1) A consolidation of HUD's competitive grant programs; 2) The creation of a Rural Housing Stability Program; 3) A change in HUD's definition of homelessness and chronic homelessness; 4) A simplified match requirement; 6) An increase in prevention resources; and, 7) An increase in the emphasis on performance.

implement what works, the direction of future changes appears to fit well with lowering barriers to service based on language and culture. These changes include:

- The implementation of a coordinated entry system for families which will involve coordinated assessment and referral for anyone seeking services. Special attention will be paid to equity of access for all cultural and language groups;
- A shift away from emergency shelter and transitional housing to emphasizing prevention and rapidly housing households experiencing homelessness into permanent housing;
- Changes in how services are provided – new attention is being paid to preserving households' natural support networks and offering a choice in terms of geographic preference; and
- Stronger linkages to economic opportunity. These will help to increase household income, thereby decreasing severe housing cost burden (e.g. households paying more than 50 percent of monthly income on rent).

Commitment 4 - Support Improved Data Collection and Coordination of Evaluation Efforts

Throughout 2010, CSD staff worked with Safe Harbors HMIS staff to improve the consistency of agency participation and quality of data collected in Safe Harbors.

Safe Harbors staff contracted with an outside consultant to review agency participation and provide recommendations. Based upon this study, Safe Harbors staff improved access to training and help desk resources. They also created consistent dashboards to monitor agency participation and quality of data entry.

Safe Harbors staffs' efforts were unable to improve the quality of outcomes data for clients served in 2009. By fall 2010, dashboards were implemented and agencies received increased training and follow-up to improve data quality. Regular meetings have been held with Seattle and King County contract monitors. In 2010, the continued oversight of the data and contractors has resulted in improved data quality and consistency; however it continues to be a challenge requiring tremendous staff involvement.

In January 2011, CSD evaluation staff will begin to review the 2010 data set for quality.

In 2010, CSD evaluation staff worked with United Way and MHCADSD to convene meetings of evaluators working in the area of homeless services and policy. The meetings resulted in two sub-groups. One was to share data on service costs to create a standardized taxonomy for cost-benefit analysis. The second sub-group met to discuss how we evaluate outreach projects and define success.

CONCLUSION AND RECOMMENDATIONS

This report found that service parity levels have remained near constant for all of DCHS' target services as compared to the previous two years' analyses. The only DCHS target service accessed by all racial/ethnic groups at near parity was Birth-to-Three early intervention services. For outpatient mental health treatment, outpatient substance abuse treatment, and homeless services, one or more People of Color racial/ethnic groups were significantly over or under represented respectively among these services.

- Asians/Pacific Islanders were found to be substantially underrepresented among outpatient mental health treatment, outpatient substance abuse treatment, and homeless services clients. As described earlier, this phenomenon is partly explained by cultural norms among this population for addressing health and economic problems.

- American Indians/Alaskan Natives were heavily overrepresented among clients utilizing outpatient mental health treatment, outpatient substance abuse treatment, and homeless services.

- Blacks were slightly overrepresented among outpatient mental health treatment and outpatient substance abuse treatment clients and significantly overrepresented among homeless services clients.

- Hispanic/Latino adults were sizably underrepresented among outpatient substance abuse treatment clients.

The parity results presented in this report are useful for comparing service usage rates across racial/ethnic groups. For instance, the fact that American Indians/Alaskan Natives represent five percent of outpatient substance abuse clients and one percent of the service eligible population may indicate that this population could benefit from greater chemical dependency prevention efforts, if it is desired for all racial/ethnic groups to access these services equally.

Missing from this analysis is whether DCHS's target services are meeting different racial/ethnic group's need for these programs. According to data from the National Household Survey on Drug Abuse (NHSDA), 7.8 percent of all American Indians/Alaskan Natives over the age of 12 have a need for outpatient substance abuse treatment.[32] Countywide, 5.1% of American Indians/Alaskan Natives accessed outpatient substance abuse treatment services in 2008. Thus, it may appear that American Indians/Alaskan Natives in King County have an unmet need for outpatient substance abuse treatment services. The problem with making this side-by-side comparison is that MHCADSD's outpatient substance abuse treatment services are available only to households with incomes at or below the Federal Poverty Level (FPL). Among this sub-group of American Indians/Alaskan Natives in King County, 36% utilized outpatient substance abuse treatment services. Whether this is indicative of this sub-population's need for outpatient substance abuse treatment services being fully met is unknown. This is

[32] Office of Applied Studies - Substance Abuse and Mental Health Services Administration (SAMSHA) (2008). Prevalence of Substance Use Among Racial & Ethnic Subgroups in the U.S. http://www.oas.samhsa.gov/NHSDA/ethnic/ethn1006.htm

because reliable prevalence data on the need for outpatient substance abuse treatment, as well as any other of DCHS's target program's services, does not exist at the King County level across racial/ethnic groups and income levels.

Unfortunately, DCHS currently lacks the resources to undertake reliable prevalence studies of the need for any of its target programs' services across racial/ethnic groups and income categories in King County. DCHS' parity analyses are therefore limited by this lack of data.

Another issue limiting the findings of this report is the racial/ethnic categories used. Currently, the service data made available to DCHS is broken down by the U.S. Census Bureau's racial/ethnic groupings. These categories combine many subpopulations with sometimes vast socio-economic differences between them. Based upon this limitation, DCHS is therefore unable to identify whether certain ethnic groups such as Somalis are proportionately represented among clients of its services.

Through its work with early intervention providers, DDD will address some of these racial/ethnic categorization reporting issues. MHCADSD and CSD have limited ability to influence data reporting requirements since they are set at the federal or state level and must be followed per funding agreements.

Service Outcomes Findings

Regarding program outcomes, this report learned that provider specialization in serving particular ethnic groups can affect treatment results. MHCADSD found that Asian/Pacific Islander, Hispanic, and American Indian/Alaskan Native ethnic specialty outpatient chemical dependency treatment providers had better outcomes for their target ethnic groups than did non-specialty providers.

In its analysis of client outcomes for King County homeless housing programs, CSD found that across all of the housing cohorts studied there appears to be no statistically verifiable difference in client success rates across racial/ethnic groups.

DDD learned that its early intervention outreach program has been very successful in informing Vietnamese, Hispanic/Latino, and Somali families about early intervention services. Nonetheless, linguistic and cultural barriers seem to prevent many families from comfortably accessing services.

The issue of service barriers was also raised by CSD as one of the possible contributors to Asian/Pacific Islander underrepresentation among homeless services clients.

<u>Recommendations</u>

DCHS has focused its analysis over the last three years on several of the 'Determinants of Equity' presented in Ordinance 16948, relating to the "fair and just" principle of the 2010-2014 Countywide Strategic Plan. Specifically, these are the following:

- Early childhood development that supports nurturing relationships, high quality affordable child care and early learning opportunities promoting optimal early childhood development and school readiness for all children;

- Health and human services that are high quality, affordable, and culturally appropriate and support optimal well-being for all people; and
- Housing for all people that is safe, affordable, high quality, and healthy.

Through its research in these areas, DCHS also has implemented one of the ordinance's 'equity and social justice foundational practices' of "Increase focus on the determinants of equity in order to influence the root causes of inequities."

DCHS's research has shown that racial/ethnic trends in program utilization rates across its target programs have remained near constant over the past three years. It is therefore deemed appropriate to expand DCHS' equity and social justice analysis to sub-populations, such as ethnic groups, sexual minorities, and age ranges. This would allow DCHS researchers to discern underlying differences within and across larger racial categories.

For 2011, participating DCHS divisions have developed commitments which build upon their previous findings, explore evidence-based questions previously unaddressed, and continue to support the 'fair and just principle' of the Countywide Strategic Plan. The commitment proposals for each division are presented below in the order their sections appeared in the report.

MHCADSD

In 2011, MHCADSD intends to do a system-wide assessment on the unique mental health and substance abuse treatment needs, barriers, and potential solutions for older adults. This assessment will look at disparities in need, access, and outcomes and will serve as the basis for developing a plan to meet the unique mental health and chemical dependency prevention and treatment needs of this population. Sub-analyses will also be conducted to identify racial or ethnic modifiers of access and outcomes for this population. Among the programs to be included in this assessment are programs for older adults paid for by the Mental Illness Drug Dependency (MIDD) sales tax. MHCADSD will also explore the feasibility of including an assessment of the CSD-contracted Pearls program funded through the Vets and Human Services Levy.

DDD

Commitment 1: Update Parity Analyses of Birth-to-Three Early Intervention Enrollment Rates – Replicate previous years' analyses of enrollment rates for Birth-to-Three early intervention services across racial/ethnic groups.

Commitment 2: Analyze Outcomes for Birth-to-Three Clients – Replicate December 2010 analysis of early intervention outcomes across racial/ethnic groups.

Commitment 3 – Continued Outreach Through SOAR with Community Liaisons– Recruit, train and support additional community liaisons in the Russian and Chinese community. Adding Russian and Chinese speaking community liaisons to our cadre of qualified Somali, Hispanic/Latino and Vietnamese Family Resource Coordinators will increase DDD's goal of providing ongoing services to bilingual/ bicultural communities. Also, organize training for community liaisons on leadership, outreach, education and the Developmental Disabilities Early Intervention system.

Commitment 4: Assess Changes in Early Intervention Enrollment Rates for Russian, Chinese, Somali, Vietnamese, and Hispanic/Latino communities – Work with early intervention providers to determine potential methods to involve them in reporting and analyzing changes in enrollment for early intervention and prevention services for Russian, Chinese, Somali, Vietnamese and Hispanic/Latino families. A parallel process will be to gather additional data required by school districts regarding ethnicity and develop a baseline using the new ethnic categories.

Commitment 5 – Provide Networking/Training Events for Early Intervention Providers Serving Underrepresented Communities –Work with early intervention providers to coordinate a learning internship for community liaisons. Also, make recommendations for long-term integration of community liaisons into the Early Intervention System and sponsor six community developmental screening events prioritizing bilingual/bicultural community gatherings.

CSD

In 2011, CSD will do an assessment of its Housing and Housing Support Services Fund RFP processes. The assessment will include interviews and a survey of successful and non-successful service providers who service immigrant and refugee populations to determine if there are barriers to their access to funding resources.

Collaborating with the Initiative to End Family Homelessness, CSD will work with funders to review capital RFP processes to determine if policy should shift to the creation of larger affordable housing units, appropriate for larger immigrant and refugee family households.

APPENDIX A – FINDINGS FROM DCHS' APRIL 2009 AND DECEMBER 2009 ESJI COMMITMENTS REPORTS

April 2009 ESJI Commitments Report

In April 2009, DCHS published its first ESJI commitments report. This report focused primarily on whether any racial/ethnic groups for which data was available were disproportionately represented among the population of clients utilizing each of its three target programs. The key findings from this analysis were:

Birth-to-Three Early Intervention Services

- American Indians/Alaskan Natives, Blacks, and Whites accessed Birth-to-Three early intervention services at near parity. In contrast, Asians were well underrepresented amongst clients of these services whereas Pacific Islanders and Hispanics/Latinos were well overrepresented.

All Other Target Programs

- Asians/Pacific Islanders were well below parity in service utilization rates. They were underrepresented by rates of 100 percent to 240 percent in these programs.

- American Indians/Alaskan Natives utilized all programs at above parity, particularly outpatient chemical dependency treatment, opiate substitution treatment, and homeless services.

- Black adults (age 25 to 64) and older adults accessed outpatient mental health treatment at near parity. For outpatient chemical dependency treatment, both of these groups were overrepresented, particularly Black older adults[33]. Black children/youth (under age 25) were below parity in accessing both outpatient mental health and outpatient substance abuse treatment[34]. In general, Blacks utilized homeless services at rates well above parity, being overrepresented by 150 percent.

- Hispanics/Latinos accessed outpatient mental health and outpatient chemical dependency treatment at near three-quarters of parity, although older adult Hispanics/Latinos were overrepresented among outpatient mental health treatment clients by 250 percent. For homeless services, Hispanics/Latinos were underrepresented among clients by over 200 percent[35].

[33] Substance abuse data for older adults cannot be broken down between outpatient and opiate substitution treatment. Black adults accessed opiate substitution treatment at slightly below parity.
[34] Children/youth under 18 are not legally allowed to access opiate substitution treatment.
[35] In 2009, CSD researchers changed their categorization of Hispanic/Latino from a race to that of an ethnicity, in accordance with US Census Bureau standards. This change resulted in Hispanics/Latinos being slightly overrepresented among CSD-funded homeless services program clients.

December 2009 ESJI Commitments Report

To track the above findings in service utilization rates across its three target programs, DCHS published its second ESJI Commitments Report in December 2009. An additional component of this analysis was determining whether racial/ethnic differences were present for client outcomes in each of its target programs. This research concluded:

Service Access

- Service utilization rates across racial/ethnic groups remained near constant for clients of Birth-to-Three early intervention services, outpatient mental health treatment, outpatient substance abuse treatment, and opiate substitution treatment.

- For homeless services, utilization rates remained nearly unchanged for Whites, Asians/Pacific Islanders, and American Indians/Alaskan Natives. Blacks accessed homeless services programs at a slightly lower rate in 2009. The reason for this change may have been a categorization issue, in that the corresponding rate for persons of Two or More Races increased slightly. Hispanics/Latinos were re-categorized by CSD researchers in 2009, from being a race to that of an ethnicity. This changed their percentage of CSD-funded homeless services clients; resulting in their being overrepresented by over 150 percent.

Program Outcomes

Outpatient Mental Health Treatment Outcomes

- EMPLOYMENT– Individuals across racial/ethnic groups who were unemployed at the start of their mental health benefit[36] had nearly equally poor results gaining employment by the end of 2008.

- HOUSING AND HOMELESSNESS- Virtually all individuals across racial/ethnic groups who were housed at the beginning of their mental health benefits maintained their housing throughout their benefit period.

- MAINTENANCE AND IMPROVEMENT OF FUNCTIONING[37]- As a combined category, outcomes were near equal across all racial/ethnic groups for maintenance and improvement of functioning.

- INCARCERATION REDUCTION- Incarceration rates dropped comparably among youth from all racial/ethnic groups, though the small numbers of clients served make this finding unreliable.

[36] This refers to the twelve-month period for which contracted mental health providers typically receive funding for each individual client.

[37] For people six years of age or older who received services under a year-long outpatient benefit, improvement or maintenance is based on change in the level of functioning scale that is appropriate for the individual's age (the "Children's Global Assessment Scale" for those six to 17, or the "Global Assessment of Functioning" scale for those 18 and older) from the start of the benefit to the end of the benefit. This scale is one component of the diagnosis that is used for mental or behavioral disorders. Improvement on either of these scales is defined as an increase of one or more points. Maintenance is no change in points.

There were impressive reductions in adult incarcerations across all racial and ethnic groups, from a low of 67.5 percent improvement for Blacks to a high of 86.8 percent improvement for American Indians/Alaskan Natives.

Outpatient Substance Abuse Treatment Outcomes

- TREATMENT COMPLETION AND RETENTION- Adult and youth treatment completion and retention rates improved for all racial/ethnic groups from 2004 to 2008. The greatest improvements were seen among treatment completion rates for Blacks. Treatment completion rates increased by more than 90% for adults and by approximately 125% for youth in this group.

Birth-to-Three Early Intervention Services

- Due to the small numbers of children from all racial/ethnic groups except Whites utilizing early intervention services, outcome findings were unreliable.

- From 2004 to 2008, the number of children achieving age appropriate milestones by the time they exited early intervention services steadily increased for all racial/ethnic groups, with the exception of American Indians/Alaskan Natives[38].

Homeless Services

- No statistically significant differences were found[39] in the rates by which people of color versus White clients moved from homeless to transitional or permanent housing.

- In analyzing outcomes across racial/ethnic groups, the only statistically significant finding was that Hispanic/Latino families in emergency shelters were less likely to move to transitional or permanent housing than any other racial/ethnic group residing in emergency shelters[40].

[38] It should be noted that three or fewer American Indian/Alaskan Native children exited early intervention services in each of the years from 2004 to 2008.

[39] This analysis was conducted using a de-identified 2008 client data set from Safe Harbors, King County's web-based Homeless Management Information System (HMIS). Clients were identified as having met successful outcome criteria by meeting three HMIS data elements (reason for leaving, move destination and types of housing moved to). Those clients with enough data were separated into cohorts for outcomes analysis: Family Emergency Shelter (742 persons); Family Transitional Housing (165 persons); Single Emergency Shelter (5,716 individuals); and Single Transitional Housing (602 persons). Data for the latter cohort was too incomplete to do accurate analysis – only 295 cases of 5,716 individuals met the criteria for outcomes analysis.

[40] It should be noted that the numbers of Asians/Pacific Islanders and American Indian/Alaskan Native clients in each cohort with complete exit data were too small to conduct valid analysis.